2023 ESTIMATES NOTES – Table of Contents

2023 ESTIMATES NOTES – Table of Contents

2023 ESTIMATES NOTES – Table of Contents

2023 ESTIMATES NOTES – Table of Contents

LEGISLATIVE SESSION – ESTIMATES NOTE

Canada Health Transfer and Bilateral Funding Agreements

Topic: Status of the Canada Health Transfer (CHT) and other bilateral funding agreements, including the Home and Community Care and Mental Health and Addictions Services (HCCMHAS) Funding Agreement.

Key Messaging and Recommended Response:

- **In Budget 2023, BC is investing $6.4 billion over three years to strengthen our health care system, including mental health services, cancer care, primary care, and to support the doctors, nurses, and health care workers we depend on for care every day.**
- **This builds on the significant investments made since 2107 to improve health care for all British Columbians.**
- **Former Premier John Horgan and the BC government alongside the other Provinces advocated tirelessly for an increase in health care funding from the federal government.**
- **In February 2023, the federal government presented Premiers with a new federal health funding plan, including new bilateral agreements to support health care.**
- **In March 2023, BC announced agreement in principle to support new bilateral funding, which includes over $3.3 billion over 10 years for targeted funding in priority areas such as:**
- **Expanding access to family health services, including in rural and remote areas;**
- **Reducing backlogs and better support BC's health-care workers;**
- **Modernizing how we track and report health data; and,**
- **Improving access to mental health and addictions services.**
- **Investments will further support long-term care (LTC), home care and improving credentialing pathways for both Canadian graduates and internationally educated health professionals.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- For BC's Budget 2023, the revenue assumptions for the Canada Health Transfer and other health related federal government transfers total **$6.9 billion**, including:
    - $6.733 billion for the Canada Health Transfer;
    - $82 million for Home and Community Care; and
    - $82 million for Mental Health and Substance Use
- Recent announcements about increased federal government transfers to support health care services are **not** included in the revenue assumptions for Budget 2023 due to timing.
- The Prime Minister presented Premiers with a federal health funding plan on February 7, 2023, and on March 1, 2023, the BC government announced agreement in principle to support new bilateral funding of **$3.3 billion** over 10 years to help address shared health care priorities.[1]
- The federal government announced further details on planned federal funding of $27.5 billion over 10 years in BC, including the $3.3 billion for a new bilateral agreement and a one-time $273 million CHT top-up in 2023/24.
- Further details regarding federal plans for both Personal Support Workers Wage Support and the Indigenous Health Equity Fund are still being communicated to Provinces and Territories.
- The announced federal funding is still subject to completing agreements with Provinces and Territories as well federal government approvals and authorities through their budget process.
- The 1 year extension to the existing HCCMHAS expired on March 31, 2023. The next 4 years of the HCCMHAS will be rolled into the new bilateral agreements.

FINANCIAL IMPLICATIONS

- In 2022/23, the Ministry received over $6.17 billion from the CHT, and approximately $205.5 million in additional federal funding, which accounted for just under 23% of health spending.
- In 2023/24, the Ministry will receive about a 1% increase in total federal funding due to the February 7, 2023 announcement; making the federal contribution to health spending in BC about 24%.

KEY BACKGROUND

- Federal funding for health care is primarily provided through the CHT.
- Since 2017, the CHT growth rate/escalator has been based on Gross Domestic Product growth (with a floor of 3%).

Intergovernmental Communications

- The HCCMHAS 10-year Agreement started in 2017/18 and, in August 2021, BC and Canada agreed to amend the HCCMHAS to allow for a one-time payment of approximately $135 million in Safe Long-Term Care funding.
- The first 5-year term of the HCCMHAS Agreement was set to expire on March 31, 2022. To ensure continuity of existing programs, Health Canada and PTs negotiated a 1 year extension of the HCCMHAS, with $163.966 million in BC funding for 2022/23.
- On February 7, 2023 Premiers were presented with a federal offer on health care spending, including tailored bilateral agreements including the remaining 4 years of HCCMHAS, and Premiers accepted the offer on February 13, 2023, subject to final bilateral agreements.

Intergovernmental Communications

[1] https://pm.gc.ca/en/news/news-releases/2023/02/07/working-together-improve-health-care-canadians
Intergovernmental Communications

- The first bilateral agreement will cover the 4 shared health priorities and deliver new funding in tandem with the remaining 4 years of funding from the mental health and substance use portion of the HCCMHAS.
- The second agreement will focus on the separate fifth priority of aging with dignity, combining the funds offered for LTC with the remaining 4 years of the home and community care portion of the HCCMHAS. It will also include the funding to support personal support workers.

LAST UPDATED

The content of this fact sheet is current as of April 5, 2023 as confirmed by Darlene Therrien.

APPROVALS

2023 03 13 – Rob Byers, Finance and Corporate Services
2023 04 06 – Darlene Therrien, Intergovernmental Relations
2023 04 12 – Jonathan Dubé, Associate DM, Health System Operations

[3] Government of Canada, February 7, 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

Ministry of Health
Confidential: Advice to Minister - Canada Health Transfer

($ millions)	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
								Government Financial Information	
Canada Health Transfer	5,004.00	5,204.00	5,467.00	5,678.00	5,865.00	6,176.00	7,107.00		
Additional Federal Funding			9.783	1,628.65	357.73	205.50	577.00		
Total Federal Funding (note 1)	5,004.00	5,204.00	5,476.78	7,306.65	6,222.73	6,381.50	7,684.00		
Year over Year % Change		4.00%	5.24%	33.41%	-14.83%	2.55%	20.41%		
Total Health Sector Spend (note2)	20,927.00	22,151.00	23,449.00	25,605.00	27,584.00	27,737.00	29,906.51		
Year over Year % Change		5.85%	5.86%	9.19%	7.73%	0.55%	7.82%		
Canada Health Transfer as a percentage of Health Sector Spend	23.9%	23.5%	23.3%	22.2%	21.3%	22.3%	23.8%		
Total Federal Funding as a percentage of Health Sector Spend	23.9%	23.5%	23.4%	28.5%	22.6%	23.0%	25.7%		

Note 1

Additional Federal funding is recognized in the year received
2023/24 Federal funding amounts are agreement in principle as identified in the Feb 7, 2023 First Ministers' Meeting
2023/24 amounts may vary from amounts reported by the Ministry of Finance on Budget Day

Note 2

2022/23 is Quarter 2 Forecast
Reduction in expenditures in 2022/23 due to COVID
2023/24 includes Ministry of Health Budget ($28.673 billion) and Contingencies Access ($1.233 billion including $875 million for COVID)
2024/25 includes Ministry of Health Budget ($29.877 billion) and Contingencies Access ($472 million)

Health Canada: Working To

Working Together to Improve Health Care for Canadians

British Columbia[1]

($Millions)	23-24	24-25	25-26	26-27	27-28	5-Year total	28-29	29-30	30-31	31-32	32-33	10-Year total
Canada Health Transfer[2]		Government Financial Information					Government Financial Information					
Growth since 2022-23	657					6,602						21,449
CHT top-up for paediatric hospitals and emergency rooms[3]	273					273						273
CHT 5% guarantee[4]	0					686						2,436
Total CHT	931					7,561						24,158
Tailored Bilateral Agreements												
Bilateral agreements	329					1,654						3,321
Sub-total: CHT and bilateral agreements	1,259					9,215						27,479
PSW wage support												
PSW						To be det						
Other Bilateral Agreements												
Mental health and substance use	83					334						334
Home and community care	83					334						334
Long-term care	82					413						413
Sub-total	248					1,081						1,081
TOTAL	1,507					10,296						28,560

[1] Provincial / territorial allocations are based on the M1 Scenario of Statistics Canada's population projection, released on August 22, 2022 (Table 17-10-0057-01), unless otherwise noted.
[2] All Canada Health Transfer amounts starting in 2024-25 are notional, estimated based on December private sector nominal GDP forecast, and are subject to change.
[3] Federal payment to be recorded in 2022-23, using Statistics Canada's June 1, 2022 population data.
[4] Provides participating jurisdictions top-up payments to ensure 5 per cent growth for five years, to rolled into the CHT base after 2027-28.

LEGISLATIVE SESSION – ESTIMATES NOTE

'In Plain Sight' Report Recommendations Implementation

Topic: The 'In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care' (IPS) report, was released publicly on November 30, 2020, and includes 24 recommendations to address systemic Indigenous-specific racism in the provincial health system.

Key Messaging and Recommended Response:

- **The In Plain Sight Report (IPS) demonstrated a clear need to make significant changes in our health-care system to address systemic failures.**
- **In response, we are making meaningful progress on the implementation of the IPS recommendations.**
- **Several legislative priorities have been achieved, including the Health Professions and Occupations Act, Anti-Racism Data Act, Human Rights Code amendment, and Public Interest Disclosure Act.**
- **Apology statements were issued by the Minister of Health, Board Chairs and CEOs from regional health authorities, and various medical colleges in 2020 and 2021.**
- **A provincial Patient Care Quality Safety Collaborative has been established to improve patient complaints processes and share promising practices.**
- **The implementation period for the 2018 Memorandum of Understanding on Mental Health and Wellness Services has been extended to October 1, 2023.**
- **Métis Nation BC has established an internal table to advance In Plain Sight recommendations, while the BC Cultural Safety and Humility organizational standard was published in June 2022.**
- **Progress has been made on data sharing and systemic performance monitoring, as well as medical transportation and ambulance services for communities during the COVID-19 pandemic.**
- **All health authorities have appointed Indigenous board members and established new Vice President, Indigenous Health positions.**
- **Collaboration with the Ministry of Advanced Education and Skills Training is underway to advance recommendations specific to post-secondary education institutions, and the National Collaborating Center for Indigenous Health has**

received funding as a center for anti-racism, cultural safety, and trauma-informed standards.

- **We will continue our efforts until all IPS recommendations are implemented in our health-care system.**

CURRENT SITUATION

Recommendation #1 - The Minister of Health issued an apology statement to Indigenous people on November 30, 2020. On December 1, 2020, a joint written apology on behalf of all Board Chairs and CEOs from regional health authorities (HAs) and Provincial Health Services Authority (PHSA) was issued. On May 11, 2021, written apologies were also issued by the BC College of Nurses and Midwives, the College of Physicians and Surgeons of BC, the College of Dental Surgeons of BC, and the College of Pharmacists of BC.

Multiple legislation priorities have been achieved specific to IPS recommendations including the following:

Recommendation #2

- The ***Health Professions and Occupations Act*** passed royal assent on November 22, 2022.
- On June 2, 2022, the ***Anti-Racism Data Act*** **(ARDA)** became law in BC.
- The Ministry of Attorney General is in the early stages of conducting internal engagements for the upcoming ***Anti-Racism Act***.
- The **Human Rights Code** was amended in November 2021 to include Indigenous identity as a ground for discrimination.
- In July 2021, the Province announced the ***Public Interest Disclosure Act*** will be applicable to employees of health authorities in June 2023, supporting whistleblower protections and a "Speak Up Culture".

Recommendation #5

- A provincial Patient Care Quality Safety Collaborative has been established to share promising practices and support improvements in patient complaints processes. The Collaborative is currently working though an inventory of actions to be implemented in each locale that supports complaints and feedback. Further, members of the collaborative, as well as health regulators and education partners attended a 2-day Workshop regarding Restorative Approaches (Relationally Based Approaches to healing from Health Care Harms) on October 5-6, 2022.
- The BC Patient Safety and Quality Council has, in partnership with the In Plain Sight Task Team, published the "Sharing Concerns: Principles to Guide the Development of an Indigenous Patient Feedback Process". This publication identifies core principles of a safe, accessible, and meaningful patient complaints process.

Recommendations #6, #17 – The signatory partners to the 2018 *Memorandum of Understanding: Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* (the MoU) have extended the implementation period of the MoU to October 1, 2023.

Recommendation #7 - Métis Nation BC (MNBC) has established an internal table to support their work with the Task Team and advance the recommendations from In Plain Sight.

Recommendation #8 - A BC Cultural Safety and Humility organizational standard was published in June 2022, sponsored by the First Nations Health Authority (FNHA) in partnership with the national Health Standards Organization. As with most health standards, it will not become an assessment standard, meaning one that organizations are measured by in their accreditation cycle, for at least one year.

Recommendation #9 – The Tripartite Data Quality & Sharing Agreement (TDQSA) has been extended until April 2023 and the FNHA and the Ministry are collaborating on the development of a new agreement to replace the TDQSA. A working group comprised of HAs reps, FNHA, MNBC and the Ministry has been established to improve data sharing across the system, determine a balanced indicator set to measure cultural safety across the system, and develop a standardized systemic performance monitoring dashboard.

Recommendation #15 – As part of the ongoing response to the COVID-19 pandemic, the collaboratively developed *Rural, Remote, First Nations and Indigenous COVID-19 Response Framework* continues to support medical transportation and ambulance services for communities.

Recommendation #13 - In January 2021, the newly created position of Associate Deputy Minister of Indigenous Health and Reconciliation was filled on a temporary and then permanent basis to begin implementation of the recommendations in collaboration with Indigenous, health system, and provincial ministry partners. This was the first time an Indigenous person had been appointed as an Associate Deputy Minister in the BC public service.

Recommendation #14 - All HAs now have at least 2 Indigenous Board members. All HAs including PHSA and Providence Health Care have established new Vice President, Indigenous Health positions.

Recommendations #18, 20, 21, 22 and 23 – The Ministry of Health is working with the Ministry of Advanced Education and Skills Training (AEST) on a collaborative process to advance implementation of the Recommendations specific to post-secondary education institutions.

Recommendation #19 - The Ministry has provided $0.550 million in 2021/22 for 5 years of support to the National Collaborating Center for Indigenous Health (NCCIH) as a centre for anti-racism, cultural safety and trauma-informed standards, policy, tools, and leading practices. NCCIH is also working with health authorities to develop tools and resources to support the implementation of the BC Cultural Safety and Humility Standard.

Recommendation #24 - A Task Team was formed and launched on May 12, 2021, with Métis Nation, FNHA, First Nations Health Council, First Nations Leadership Council and system partners who hold expertise in the BC health care system, cultural safety and humility, knowledge and experience with Indigenous engagement and addressing Indigenous-specific anti-racism. Task team's mandate was for a minimum 24-month term at which point it must prepare a public report on progress in implementing all 24 recommendations.

FINANCIAL IMPLICATIONS

Budget 2021 provided $15 million annually to support the work of the In Plain Sight Task Team, culturally safe health services and more Indigenous liaisons in each regional HA to improve health access and services for Indigenous peoples.

KEY BACKGROUND

- In June 2020, the Minister of Health commissioned an independent review into allegations of racism in the BC emergency department setting, as well as the broader health system.[1] The review concluded with both a full and summary report and a subsequent data report released in February 2021.[2]
- Additional immediate steps taken, in alignment with IPS and provincial response, include:
  - 5 new Indigenous health liaison positions are being funded in each regional HA and PHSA, plus 2 additional positions at Providence Health Care, for a total of 32 new positions.
  - Medical bylaws are under review by the Ministry, and revisions will be implemented collaboratively, for consistent cultural safety and humility standards for medical staff privileges.
- The independent review 1-800 number and email address has been transferred to the Office of the Ombudsperson and will be maintained as a reporting resource in the coming months, while processes for effective system complaints processes are strengthened.

[1] https://news.gov.bc.ca/releases/2020HLTH0198-001115
[2] Addressing Racism in BC Health Care (gov.bc.ca)

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of March 13, 2023, as confirmed by Diana Clarke, A/ Sr Executive Director, Indigenous Health and Reconciliation.

APPROVALS

2023 03 03 - Teresa Dobmeier, Indigenous Health and Reconciliation
2023 03 13 – Peter Klotz obo Rob Byers, Financial and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Indigenous Health Funding

Topic: The Ministry of Health allocates annual funding to health authorities, the First Nations Health Authority (FNHA), the BC Association of Aboriginal Friendship Centres, Métis Nation BC (MNBC), and Nations and communities to support the advancement of Indigenous health and wellness initiatives.

Key Messaging and Recommended Response:

- **Ensuring that First Nations throughout BC have the capacity to provide culturally safe services, tailored to the unique needs of the diverse experiences of over 200 First Nations communities, is crucial to the government's ongoing efforts to promote meaningful, nation-to-nation reconciliation.**
- **The Ministry is committed to supporting Indigenous health and wellness through financial contributions to various initiatives, reflecting its legal obligations and dedication to improving health outcomes for Indigenous communities.**
- **The Tripartite Framework Agreement on First Nation Health Governance (2011) serves as a cornerstone for Ministry support, fostering collaboration between Indigenous communities, the provincial government, and health authorities to enhance health services.**
- **The Memorandum of Understanding – Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness (2018) emphasizes the Ministry's focus on mental health and wellness in Indigenous communities.**
- **The Ministry provides funding to health authorities and other organizations to ensure that Indigenous health services and initiatives are accessible, culturally safe, and effective.**
- **The implementation of the In Plain Sight (IPS) recommendations demonstrates the Ministry's commitment to addressing Indigenous-specific racism and discrimination in healthcare and working towards a culturally safe healthcare system for all Indigenous Peoples.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

The Ministry of Health provides ongoing financial supports for Indigenous-specific health and wellness initiatives through mandated Ministry service planning and its legal obligations including; the *Tripartite Framework Agreement on First Nation Health Governance* (2011); the *Memorandum of Understanding – Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* (2018); and funding to health authorities and other organizations for Indigenous health services and initiatives including implementation of the *In Plain Sight* (IPS) recommendations.

FINANCIAL IMPLICATIONS

In 2022/23 the Ministry committed the following funding as identified above to support Indigenous Health:

- $55.7 million to the FNHA,
- $10.4 million to health authorities.
- $0.200 million to the BC Association of Aboriginal Friendship Centres.
- $0.825 million to Métis Nation BC.

KEY FACTS

Health Authorities

A total of $10.4 million of base funding was allocated to HAs ($4.9M in 2020/21 and $5.5 in 2021/22) for priorities aligned with the IPS Sight recommendations including: 1) Indigenous recruitment and retention; 2) improving the complaints system; 3) furthering Cultural Safety and Humility and, 4) an additional 32 Indigenous Health Liaison positions.

FNHA

- The Ministry supports the *Tripartite Framework Agreement on First Nations Health Governance* (2011) with contributions to FNHA of $100 million from 2006/07 to 2019/20. The Ministry provided a further lump sum of $22 million in 2019/20 to further support the FNHA.
- Initially developed in support of the 2013 *"Agreement in Lieu of Medical Services Plan (MSP) Premiums on Behalf of First Nations People Resident in the Province of BC"* the Ministry commits up to $15.33 million annually to support 27 primary care projects overseen by the Ministry-FNHA Joint Project Board.
- For 2019/20 – 2020/21, annual funding of $595,000 was provided to support the enhancement of cultural safety and humility through the implementation of the Change Leadership Strategy endorsed under the Tripartite Committee on First Nations Health.
- The Ministry provided FNHA $3.6 million in 2021/22 for virtual Doctor of the Day programs and for Substance Use and Psychiatry programs and service delivery.
- The FNHA funding letter supports the Ministry-FNHA annual Letter of Mutual Accountability (LMA). The 2022/2023 LMA covers the period from April 1, 2022, to March 31, 2023.
- Provincial funding to FNHA in 2020/21 included support for Indigenous Land-based substance use services, Indigenous Suicide and Critical Incident Response Team Expansion, and Indigenous health and culturally appropriate services as part of *A Framework For Action: Responding to the Toxic Drug Crisis for First Nations*.
- The Ministry also committed $1.0 million per year to FNHA starting in 2021/22 through 2023/24 for the development and implementation of a Traditional Healing and Wellness Strategy, and to support continued efforts identified in the Letter of Mutual Accountability and the implementation of the *IPS* recommendations.
- In 2020/21 the Ministry provided FNHA $1.23 million for COVID-19 pandemic response. In 2021/22, the Ministry provided FNHA with $16.68 million in COVID-19 funding, including $5.88 million to support COVID-19 contact tracers and $10.8 million to support the Rural Remote Collaborative.

BC Association of Aboriginal Friendship Centres

- In fiscal 2022/23, the Ministry provided the BC Association of Aboriginal Friendship Centres with a grant of $200,000 to support projects and initiatives benefiting urban and off-reserve Indigenous populations.

MNBC

The Ministry provided MNBC with a grant of $825,000 in 2022/23 to support health and wellness initiatives including partnership development; supporting the Métis Public Health Surveillance Program to help monitor health status of Métis peoples; facilitating Métis participation across the spectrum of Indigenous engagement, access, decision-making, and working relationships with health partners and participation in the provincial response to the IPS report with a focus on building human resource capacity to strengthen MNBC capacity for Métis engagement on IPS recommendations.

National Collaborating Centre for Indigenous Health (NCCIH)

The Ministry provided $550,000 in 2020/21 to support NCCIH's work with health system partners to develop tools, strategies, training, and resources to enhance culturally safe service delivery and practices across the BC health system. Support for the NCCIH aligns with Rec. #19 from the IPS report. The Ministry provided $850,000 in 2021/22 to NCCIH through the University of Northern BC to work with the VPs of Indigenous Health and health system partners to advance initiatives related to the implementation of the new Cultural Safety and Humility standard, Indigenous Cultural Safety measurement and education and training.

Memorandum of Understanding (MOU) on the Determinants of Health and Wellness

- The 2018 tripartite *MoU – Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* provides provincial support through the Ministry, Ministry of Mental Health and Addictions (MMHA), Ministry of Children and Family Development (MCFD), and Ministry of Indigenous Relations and Reconciliation (MIRR).
- The Ministry (representing contributions from MoH, MIRR, MCFD, and MMHA) provided the FNHA $5.0 million in 2018/19 and 2019/20 to support the Tripartite Partnership to Improve Mental Health and Wellness, as part of BC's $10 million commitment to support planning and implementation of Nation-based plans and initiatives. The implementation period for this funding has been extended until October 1, 2023.
- In 2019, the Province provided $20 million (matched by FNHA totaling $40 million) to build and revitalize First Nations treatment centres across the Province. Federal Budget 2021 provided an additional $20 million from the Government of Canada to support this initiative, for a final combined allocation of $60 million.[1]

University of BC (UBC)

The Ministry provided one time funding of $550,000 to UBC (through the Ministry of Advanced Education and Skills Training) to support core elements of UBC's proposal for expanding their Indigenous Cultural Safety program in response to the Truth and Reconciliation Commission's Calls to Action #23 and #24.

LAST UPDATED

The content of this fact sheet is current as of February 27, 2023, as confirmed by Teresa Dobmeier, Associate Deputy Minister, Indigenous Health and Reconciliation.

APPROVALS

2023 02 27 - Teresa Dobmeier, Indigenous Health and Reconciliation.
2023 03 24 - Peter Klotz, obo Rob Byers, Finance and Corporate Services Division

[1] Indigenous Services Canada. (2021, August 14). *Government of Canada highlights funding for Indigenous communities to support critical infrastructure*. Retrieved September 15, 2021 from: https://www.canada.ca/en/indigenous-services-canada/news/2021/08/government-of-canada-highlights-funding-for-indigenous-communities-to-support-critical-infrastructure.html

LEGISLATIVE SESSION – ESTIMATES NOTE

Ministry Declaration Action Plan Commitments

Topic: The Government of BC has committed to true and lasting reconciliation with Indigenous peoples.

Key Messaging and Recommended Response:

- **Our government passed the Declaration on the Rights of Indigenous Peoples Act (DRIPA) in 2019 to establish UNDRIP as a framework for reconciliation.**
- **The DRIPA Action Plan was released in March 2022, assigning responsibility for each action to the appropriate ministries.**
- **By passing DRIPA, we made a commitment that the laws our government passes and the services we deliver are aligned with the unique and diverse experiences with Indigenous Peoples in BC.**
- **As part of the Ministry of Health's DRIPA Action Plan, the Ministry is implementing the recommendations of the In Plain Sight report to create a culturally safe, racism-free health care system, in addition to:**
    - **partnering with the Ministry of Mental Health and Addictions (MMHA) to develop a flexible funding model supporting First Nations mental health and wellness services.**
    - **prioritizing the implementation of Primary Care Networks that include funding for Elders and Indigenous-led health initiatives to increase access, cultural safety, and quality of care.**
    - **Working with other ministries to increase availability and accessibility of Indigenous-led social services and supports, addressing holistic wellness needs.**
- **We will continue supporting the implementation of Tripartite and other Indigenous Health commitments, including agreements, MoUs, and initiatives to improve health and wellness.**

CURRENT SITUATION

- The Government of BC passed the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) in November 2019 to establish the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) as a framework for true and lasting reconciliation as per the Truth and Reconciliation Commission of Canada.

- The DRIPA Action Plan[1] was released March 30, 2022. The Action Plan clearly attaches responsibility for the delivery of each action within the five-year plan with the appropriate ministries.

The following items from the DRIPA Action Plan are specific to the Ministry (some with shared responsibility):

- 3.7 - Implement recommendations made in the *In Plain Sight: Addressing Indigenous-specific racism and discrimination in B.C. health care* report, striving to establish a health care system in BC that is culturally safe and free of Indigenous-specific racism. (The Ministry)
- 4.7 - Demonstrate a new and more flexible funding model and partnership approach that supports First Nations to plan, design and deliver mental health and wellness services across a full continuum of care and to address the social determinants of health and wellness. (The Ministry, Ministry of Mental Health and Addictions [MMHA])
- 4.8 - In alignment with the tripartite health plans and agreements, continue to strengthen and evolve the First Nation health governance structure in BC to ensure First Nations are supported to participate as full and equal partners in decision-making and service delivery at local, regional, and provincial levels, and engage First Nations and the Government of Canada on the need for legislation as envisioned in the tripartite health plans and agreements. (The Ministry, MMHA)
- 4.10 - Prioritize the implementation of Primary Care Networks, the First Nations-led Primary Health Care Initiative, and other primary care priorities, embedding Indigenous perspectives and priorities into models of care to increase Indigenous Peoples' access to primary care and other health services, and to improve cultural safety and quality of care. (The Ministry)
- 4.11 - Increase the availability, accessibility, and the continuum of Indigenous-led and community-based social services and supports that are trauma-informed, culturally safe, and relevant, and address a range of holistic wellness needs for those who are in crisis, at-risk or have experienced violence, trauma and/or significant loss. (Ministry of Public Safety and Solicitor General, The Ministry, MMHA)
- 4.13 - Increase the availability and accessibility of culturally safe substance use services, including through the renovation and construction of Indigenous-run treatment centres and the integration of land based and traditional approaches to healing. (The Ministry, MMHA)
- 4.14 - Increase the availability and accessibility of resources to Indigenous partners in COVID-19 pandemic health and wellness planning and response, including the implementation of the *Rural, Remote, First Nations and Indigenous COVID-19 Framework*[2] to ensure access for all Indigenous Peoples to immediate and culturally safe and relevant care closer to home. (The Ministry, MMHA)
- 4.26 - Strengthen the health and wellness partnership between Métis Nation BC, the Ministry and the MMHA and support opportunities to identify and work to address shared Métis health and wellness priorities. (The Ministry, MMHA)

In 2006, the Ministry signed the Métis Nation Relationship Accord which set out objectives to address health, housing, education, economic opportunities, Métis identification and data collection as well as any opportunities for engaging in a tripartite relationship with the federal government. The Accord was renewed in 2016 (Métis Nation Relationship Accord II) and includes the following additional areas of focus: children and families, information sharing, justice, and wildlife stewardship.

Ongoing work that supports the implementation of Tripartite and other Indigenous Health commitments include:

- Collaborative implementation of the *British Columbia Tripartite Framework Agreement on First Nations Health Governance* (2011).
- 2015 *Protocol on the Social Determinants of Health*, signed by the First Nations Leadership Council, signing of the *Declaration of Commitment to Cultural Safety and Humility in Health Services* (2015), and supporting the implementation of the change leadership strategy to embed cultural safety in the health system.

[1] https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/indigenous-relations-reconciliation/declaration_act_action_plan.pdf
[2] https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/emergency-preparedness-response-recovery/gdx/rural-and-remote-covid-19-response-framework.pdf

- 2016 bilateral Memorandum of Understanding (MoU) – *A Regional Engagement Process and Partnership to Develop a Shared Ten-Year Social Determinants Strategy for First Nation Peoples in BC* laid the foundation for 2 years of regional engagement sessions between provincial social ministries and First Nations leadership, culminating in a tripartite MoU.
- 2018 tripartite MoU – Supporting community-driven, Nation-based initiatives to improve mental health and wellness through the *Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness.* The Ministers of Health, Mental Health and Addictions, Children and Family Development, and Indigenous Relations and Reconciliation are signatories to the MoU, the implementation period of which has been extended to October 1, 2023.
- Engaging Indigenous partners in health system planning and implementation processes, including working to integrate First Nations team-based supports into regional/provincial health care systems (e.g., Elders and traditional healers), and establishing up to 15 First Nations Primary Health Care Initiative sites, two of which (Lu'ma Medical Centre and the Williams Lake First Nations Wellness Centre) are now operational with 10 more in active planning.
- Partnering with the Office of the Provincial Health Officer, FNHA, and Métis Nation BC to enhance population health and wellness monitoring and reporting through the Population Health and Wellness Agenda, the baseline report[3] of which was released publicly on June 3, 2021. The Métis Public Health Surveillance Program Baseline Report[4] was released on February 3, 2022.

FINANCIAL IMPLICATIONS

Financial implications for specific actions (e.g. implementing *In Plain Sight* recommendations) are detailed in the Indigenous Health Expenditures Fact Sheet.

KEY BACKGROUND

The Government of BC has also implemented a Declaration Act Secretariat which will support the development of guidelines for Section 3 of DRIPA, the Alignment of Laws which states "*In consultation and cooperation with the Indigenous peoples in British Columbia, the government must take all measures necessary to ensure the laws of British Columbia are consistent with the Declaration*.". The Ministry is continuing to work closely with MIRR to ensure all legislative and regulatory changes meet the spirit, intent and obligations of the Province under DRIPA.

LAST UPDATED

The content of this fact sheet is current as of February 27, 2023, as confirmed by Teresa Dobmeier, Associate Deputy Minister, Indigenous Health and Reconciliation.

APPROVALS

2023 02 27 - Teresa Dobmeier, Indigenous Health and Reconciliation

[3] https://www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda.pdf
[4] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/pho_metis_report_2021c_f3.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

Budget 2023 Overview

Topic: Health care is a top priority for the province and government will continue to make significant investments to support the public health system in BC and ensure people can access the care they need when they need it.

Key Messaging and Recommended Response:

- **Budget 2023 provides new funding of $8.9 billion over the next three years to support health care services.**
- **The 2023/24 budget for health is $28.7 billion, which represents an almost $10 billion increase since 2017 [Note: Does not include time-limited Contingencies for COVID-19].**

CURRENT SITUATION

- Budget 2023 provides new funding of $8.9 billion over the next three years to support health care services.
- The 2023/24 budget for health is $28.7 billion, which represents an almost $10 billion increase since 2017 [Note: Does not include time-limited Contingencies for COVID-19].

Operating ($ millions)	2022/23	2023/24	2024/25	2025/26
Budget 2022 Restated	**25,460.293**	**26,242.673**	**27,046.941**	**27,046.941**
Budget 2023		**28,673.508**	**29,887.097**	**30,669.129**
Budget 2023 vs Budget 2022				
Plan over Plan $ Change		2,430.835	2,840.156	3,622.188
Plan over Plan % Change		9.3%	10.5%	13.4%
Year over Year $ Change		3,213.215		
Year over Year $ Change		12.6%		

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Improving Health Services

Budget 2023 provides $6.4 billion over three years to support improved health care. This includes:

Operating ($ millions)		2023/24	2024/25	2025/26	Total
General Health Services		$ 556	$ 611	$ 1,440	$ 2,607
Heath Workforce Strategy		273	350	373	995
Primary Care	Base	189	175	116	481
	Contingencies	210	213	148	571
COVID	Contingencies	875	-	-	875
Mental Health, Addictions & Treatment Services	Base	51	38	39	128
	Contingencies	148	259	332	739
Total		**$ 2,302**	**$ 1,646**	**$ 2,448**	**$ 6,396**
	Base	1,069	1,174	1,968	4,211
	Contingency	1,233	472	480	2,185

LEGISLATIVE SESSION – ESTIMATES NOTE

Demand for Health Services

$2.6 billion over three years to support the growing demand for health services, which includes:

- Caring for a growing and aging population;
- Services delivered under MSP and PharmaCare; and
- **$270 million** over three years for cancer care as part of government's $440 million initial investment in BC's 10-Year Cancer Action Plan, which will expand access to cancer services, improve cancer-screening programs, and support recruitment and retention of oncologists.

Health Workforce Strategy

- Nearly $1 billion ($995 million) over three years to support government's health workforce strategy that was released in September 2022 and will focus on four key areas:
    - **Retain**: Foster healthy, safe and inspired workplaces, supporting workforce health and wellness, embedding reconciliation, diversity, inclusion and cultural safety and better supporting and retaining workers in high-need areas, building clinical leadership capacity and increasing engagement.
    - **Redesign**: Balance workloads and staffing levels to optimize quality of care by optimizing scope of practice, expanding and enhancing team-based care, redesigning workflows and adopting enabling technologies.
    - **Recruit**: Attract and onboard thousands of workers by reducing barriers for international health-care professionals, supporting comprehensive onboarding and promoting health-care careers to young people.
    - **Train**: Strengthening employer supported training models; enhancing earn and learn programs to support staff to advance the skills and qualifications; expanding the use of bursaries, expanding education seats for new and existing employees.
- Over the next three years, this funding will support new training programs and nearly 3,000 new post-secondary training seats, nearly 12,000 bursaries and more than 9,000 other training grants in addition to targeted financial incentives for health care staff. Funding will also support initiatives to address workplace violence, promote diversity and inclusion, and discrimination against Indigenous people while supporting the hiring of more Indigenous employees in health care.

Primary Care

- Nearly $1.1 billion (includes Contingencies funding) to implement the new compensation model for family physicians announced in October 2022 and launched in February 2023, provide recruitment and retention incentives for new to practice family physicians and those approaching retirement, and build new IT systems such as patient-clinic registries to support access to primary care services.
- The new compensation model takes into account factors including:
    - the time a doctor spends with a patient;
    - the number of patients a doctor sees in a day;
    - the number of patients a doctor supports through their office;
    - the complexity of the issues a patient is facing; and
    - administrative costs currently paid directly by family doctors.
- The Province and Doctors of BC have also reached a new Physician Master Agreement (approved by 94% of votes cast) to better support all doctors and patient care. Government is investing $708 million to support this agreement (not included in $6.4 billion above).

Mental Health, Addictions, and Treatment Services

$867 million over three years for mental health and substance use services and supports, including:

- **$586 million** in Contingencies funding over three years to provide improved treatment and recovery services for people with substance use disorders, which includes:
    - Improving community-based treatment and recovery supports, including supports for marginalized people, First Nations, and youth;
    - Establishing a seamless continuum of care to support people through their recovery journey;

  - Expanding services for people with complex and severe substance use and concurrent mental health disorders, including expansion of the Red Fish Healing Centre model; and
  - Investing in building the skilled workforce needed to support expanded services.
- $184 million to further address the illicit drug toxicity crisis, including support for safe substance use through safe prescription alternatives like diacetylmorphine and expanding prescribed safe supply. This funding will also support services for children and youth through prevention and early intervention as well as new integrated community crisis response teams like Integrated Mobile Response Programs (also known as cars programs) and planning for Indigenous-led Peer Assisted Care Teams (PACTs) ; and
- $97 million builds on previous investments in complex care housing to support more than 600 individuals. This funding also includes additional operational funding as part of a 10-year plan to provide health-focused services and resources in new purpose built complex care units.

<u>COVID-19 Pandemic</u>

- Government recognizes the significant stresses and strains on the health system, the health care workforce, and British Columbians over the last three years and the on-going challenges caused by the COVID-19 pandemic.
- In Budget 2023, government is providing Contingencies funding of $875 million in 2023/24 to support the on-going management and response to COVID-19. This funding supports:
  - ongoing COVID-19 and influenza vaccination programs;
  - provision of personal protective equipment for health care workers and COVID-19 testing;
  - enhanced screenings and additional measures to limit the risk of spreading COVID-19 to vulnerable residents in long-term care facilities, assisted living facilities, and provincial mental health facilities;
  - for people living in rural, remote, and Indigenous communities, improved medical transportation options, access to virtual care, and increased mental health supports; and
  - for the BC Centre for Disease Control to produce real-time data, modelling and analysis to support continued management of the pandemic.

<u>Other Health Investments: Free Prescription Contraception</u>

- Starting April 1, 2023, BC will be the first jurisdiction in Canada to make prescription contraception free to all residents.
- Budget 2023 provides $119 million over three years to continue to implement this government commitment and fully cover costs for prescription contraception options, including most oral hormone pills, contraceptive injections, copper and hormonal intrauterine devices, subdermal implants, and Plan B (also known as the morning after pill).
- Free prescription contraception could save someone as much as $10,000 over their lifetime.

<u>Other Health Investments: Shared Recovery Wage Mandate</u>

- Budget 2023 provides $4.6 billion over 3 years to fund compensation increases related to various collective agreements in the health sector.
- This includes $708 million to support the new Physician Master Agreement.

<u>Record Capital Investments in Health Care</u>

- Government continues to make historic investments in the expansion and upgrading of our health facilities, which will support major hospital construction projects and upgrading of health facilities, medical and diagnostic equipment, and information management/technology systems.
- This will help ensure British Columbians will have access to modern hospital and health facilities by making needed investments in areas across the province.
- As part of BC's largest ever capital investment in health care, Budget 2023 provides $11.2 billion.
- Key investments include:
  - **$2.2 billion** for new St. Paul's Hospital at the Station Street site in Vancouver with capacity for 548 inpatient beds, a new and larger emergency department, which is expected to be open for patients in 2027.

- **$1.7 billion** for a new integrated hospital and cancer centre in Surrey to help meet the needs of a growing and aging population in the region. The new hospital will have 168 inpatient beds, an emergency department, a medical imaging department, a surgical suite, a pharmacy, a laboratory, and an academic space. The new cancer centre includes an oncology ambulatory care unit, chemotherapy and radiation, a new cyclotron and space for six linear accelerators. Construction is scheduled to begin in 2023 and will be open to patients in 2027.
- **$1.4 billion** for replacement of the 54-year-old Cowichan District Hospital in Duncan with 204 inpatient beds (an increase of 70 beds), 36 emergency department spaces (increase of 19), and fixed MRI. Construction has started and will be open to patients in 2027.
- **$1.2 billion** for Phases 2 and 3 of the Royal Columbian Hospital Redevelopment for a new 348 bed acute care tower, new surgical suite with 18 operating rooms,, which is expected to be open for patients in 2025, with Phase 3 completed in 2026.
- **$861 million** for redevelopment of Richmond Hospital as part of a multi-phased project that includes 353 inpatient beds on the campus (increase of 113 beds) and a new acute care tower (216 of the 353 beds), which is expected to be open for patients in 2028.
- **$633 million** for replacement of Mills Memorial in Terrace with 83 inpatient beds (an increase of 39 beds) and expansion of the Seven Sisters mental health facility, which is expected to be completed in 2026.
- **$612 million** for Phase 1 of the Burnaby Hospital Redevelopment with new six-storey pavilion and new surgery centre, which is expected to be completed by 2027.
- **$378 million** for replacement of the Dawson Creek and District Hospital with 70 inpatient beds (an increase of 24 beds) and larger emergency department, which is expected to be completed in 2027.
- **$367 million** for redevelopment of Cariboo Memorial Hospital in Williams Lake with 53 inpatient beds (an increase of 25 beds) and new larger emergency department.
- **$332 million** for Phase 2 of the Operating Rooms Renewal at Vancouver General Hospital to improve and expand the operating suite to two floors with an additional 12 flexible operating rooms, two hybrid rooms, and a 39 bay perioperative care unit. Construction is expected to start in 2023 and be completed in 2028.
- **$310 million** for the construction of a new acute care facility at Lions Gate Hospital, which will replace 108 inpatient beds, expand the perioperative suite, supports for new and existing operating rooms, and new outpatient clinics and support services. Construction started in 2021 and is expected to be complete in 2024.
- **$224 million** for the Western Communities Long-Term Care project, which will provide a new 306-bed long term care home. Construction is to start in 2025 and be completed in 2027.
- Government Financial Information

- **$158 million** for the replacement of the Stuart Lake Hospital in Fort St. James which will be three times larger and is expected to be completed in 2024.
- To improve cancer care across BC, government is also moving forward with new cancer centres in Kamloops and Nanaimo, in addition to the new cancer centre integrated into the new Surrey Hospital Project and the new cancer centre that will be integrated into Phase 2 of the Burnaby Hospital Project.

Cost Drivers in Health Care

- Growing population – over the period 2023 to 2026, BC's population is projected to grow from 5.337 million to 5.552 million (increase of 0.215 million or 4.0%).
- Aging population – health services tend to be used at higher rates as the population ages. The BC population over 65 years of age is expected to grow from 1,104,543 in 2023 to 1,222,417 by 2026 (an increase of 118,474 or 11.1%). This also results in increased home care and residential care demands. The share of health expenditure spent on Canadians 65 and older was 46.0% in 2019. By comparison, the share spent on Canadians aged 1 to 64 was 53.0% and was 1.0% for infants younger than age 1 in 2019.

- Technology - advancement in technology and testing expands the ability to treat more people for existing conditions (e.g. hip replacements for older patients), and new and expensive treatments for previously untreatable conditions.
- Chronic disease – managing incidents of chronic disease (e.g. diabetes, renal failure, congestive heart failure).
- Drug costs – rapidly rising drug prices, especially cancer drugs and increased utilization.
- Developmental conditions - expanding treatment for developmental conditions (e.g. autism, fetal alcohol syndrome).
- Compensation pressures – negotiated compensation agreements covering six health sector bargaining units (e.g. resident doctors of BC, nurses, ambulance paramedics).
- Public health emergencies – preparing for and managing critical situations of a temporary nature that seriously endanger the lives, health and/or safety of the population (e.g. opioid overdose crisis, COVID-19).

LAST UPDATED

The content of this fact sheet is current as of 2023-04-05 as confirmed by Stephen Ward.

APPROVALS

2023 04 06 - Steve Ward, Financial Operations, Finance and Corporate Services Division
2023 04 11 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Operating Expenditures

TOPIC

In March 2020, the Public Health Officer (PHO) declared a state of emergency due to the COVID-19 pandemic. In response to this, the Ministry of Health has taken steps to minimize the impacts of this evolving public health issue.

Key Messaging and Recommended Response:

- British Columbia has taken and is continuing to take measures to respond to the COVID-19 health pandemic
- Health, health authorities and other front-line health care service delivery organizations continue to incur costs to support BC's response efforts for the impact form COVID-19 and other seasonal respiratory illnesses in Fall/Winter 2022/23
- COVID-19 transmission continues to have significant impact on the health system, both from individuals seeking care, as well as increased staff illness

CURRENT SITUATION

In 2022/23 the Ministry received approval to access Pandemic Recovery Contingencies for up to $875 million to respond to the health-care requirements of COVID-19. Up to $915 million in additional funding is available in Contingencies (page 30 of the 2022/23 – 2024/25 Budget and Fiscal Plan) if conditions require additional funding.

FINANCIAL IMPLICATIONS

As at December 31, 2022, the Ministry is forecasting the total spend to be $6.005 billion on COVID-19 operating expenses.

- $25.21 million – 2019/20
- $2.308 billion – 2020/21
- $2.194 billion – 2021/22
- $1.478 billion – 2022/23 forecast as of December 31, 2022

KEY BACKGROUND

The Ministry undertook the following actions in response to the COVID-19 pandemic:

Health Authority Funding

This represents health related COVID-19 response measures such as increased lab testing, long-term and assisted living facilities, prevention and contact tracing measures, free parking at health authority sites, personal protective equipment, accelerating rescheduled surgeries, and increased staffing across the health spectrum.

Additional Ministry Expenses

Laboratory Services

In addition to the testing done by health authorities the Ministry engaged LifeLabs and Valley Labs to complete additional COVID-19 testing.

Immunize BC Plan

- 1-833 Get Vaccinated Call Centre – The Ministry of Health established the provincial Get Vaccinated Call Centre with the support of ServiceBC, TELUS, IBM and Maximus to assist citizens with registering and booking their COVID-19 vaccinations. The call centre is a core service being delivered to support BC's COVID-19 Immunization Plan.

- Provincial Vaccine Management Platform (IMMSBC) – The Ministry of Health has implemented and launched a provincial mobile immunization and Adverse Events Following Immunization solution.
- Provincial Vaccine Distribution – The Ministry of Health has provided vaccination to eligible BC residents (5 years and older) via mass vaccination clinics, as at March 9, 2023, 85.46% of eligible BC residents have had 2 doses and 97.06% have had at least one dose of the vaccine.

Virtual Support

- HealthLink 811 Line – HealthLink BC's health service navigators navigate individuals through the health care system to find health services across the Province or connect them with health professionals. Due to a significant increase in call volume, dedicated COVID-19 navigators were hired on temporary appointments. Physicians have also been contracted to provide professional guidance related to COVID-19. Translation and interpretation service, technical support, and office expenses have been incurred to support incremental demand.
- Health Link Physician's Costs (HEiDi) – The demand for HEiDi physicians increased do to COVID. HEiDi physicians assist 8-1-1 nurses with urgent health inquiries they receive. HEiDi physicians give patients just-in-time information and comfort and ensure appropriate triage to health services. This discerning triage decreases ED wait times and can safely refer patients back to their family physicians.
- Temporary Medical Fee-For-Service (FFS) Available Amount – Several new temporary virtual FFS codes were created to expand physicians' accessibility to patients during COVID, enabling patients to access physician services with fewer in person interactions to help reduce the spread of COVID-19
- Thrive Health App – Powered by Thrive Health, the Ministry has set up an online self-assessment tool to help people determine whether they may need further assessment or testing for COVID-19.

Planning and Operations

- Consultation on Strategic Sourcing of Personal Protective Equipment (PPE) – KPMG was contracted to help secure critical priority supply items for both short term/urgent needs and for long term strategic inventory.
- Health Emergency Coordination Centre (HECC) – Acts as a provincial health coordination centre for the BC health system in the event of multi-region disasters and is designed to support the health system during emergencies. A COVID-19 project was created by HECC. Costs incurred for work on the COVID-19 project include operating expenses such as overtime, travel, and office expenses. Costs do not include Ministry staff base salaries.
- Legal Services – The Ministry obtained legal services to provide advice on human rights matters specific to COVID-19.
- Management of Staffing Movement – To limit the spread of COVID-19, Appnovation Technologies Inc. has created a website and database to obtain staffing information to support decisions about the allocation of staff to help limit staff movement between health facilities thereby reducing the spread of COVID-19.
- Medical Service Plan (MSP) Administration – Additional testing treatments were required for new COVID-related MSP claims.
- Office of the PHO Support – The PHO engaged medical consultation and communication support to assist with the COVID-19 response.
- Physician Planning Activities – Front-line physicians have been involved with the Ministry and health authorities to provide advice, review data and relevant information, and participate in front-line service delivery modifications as a result of the pandemic.
- Quarantine Income Replacement – Compensation paid to physicians under Article 9 of the Benefits Subsidiary Agreement in the Physician Master Agreement who are required by the PHO to undergo a period of quarantine as a result of exposure to a communicable disease while providing Insured Medical Services in BC.

Communications

- Advertising – Newspaper ads were incurred to inform seniors about contact information for COVID-19 related inquiries and support.

- Town Hall Meetings – The Provincial Government has hosted multiple virtual town halls to engage British Columbians in discussions regarding COVID-19.

LAST UPDATED

The content of this fact sheet is current as of April 23, 2023 as confirmed by Brenda Rafter, Executive Director, Finance and Corporate Services.

APPROVALS

2023 04 23 – Brenda Rafter, Finance and Corporate Services Division
2023 04 23 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Extra-billing - Audits and Canada Health Transfer Penalties

Topic: Several private health clinics and Medical Service Plan enrolled physicians are privately charging patients for services in contravention of the *Medicare Protection Act* (MPA) and the C*anada Health Act* (CHA). This is referred to as "extra-billing" and is prohibited under the MPA and CHA.

Key Messaging and Recommended Response:

- **Each year, BC is required to submit a report to Health Canada, quantifying the total extra-billings for a prior fiscal year. HC assesses CHT penalties based on the reported extra-billings, and federal funding is reduced in the following fiscal year as a CHA compliance deduction.**
- **To demonstrate BC's ongoing commitment to uphold the principles of the CHA and eliminate extra-billing, BC has taken a number of actions, including, contracting with private surgical clinics to bring private surgical services back into the public system, reducing wait times and increasing access.**
- **To ensure compliance, the Ministry has completed 12 audits of private surgical clinics.**
- **BC has been assessed approximately $24.2M in net penalties since March 2018.**
- **In January 2023, BC reported $23,110,530 in extra-billing for the 2020/21 fiscal. This includes $17.2M in respect of medically necessary diagnostic services.**
- **As a result of BC's corrective actions to eliminate extra-billing and user charges, in March 2023, Health Canada issued BC a $13,933,354 reimbursement for the 2020/21 CHT deductions.**
- **An audit plan for diagnostic facilities has been developed** Advice/Recommentations

Advice/Recommentations

-

CURRENT SITUATION

- In accordance with Health Canada (HC) requirements, the Province will continue extra-billing audits with the expectation the Province will receive the Canada Health Transfer (CHT) funds previously withheld by the Federal Government.
- On April 1, 2020, the Federal Diagnostics Services Policy came into effect. Advice/Recommentations

Advice/Recommentations

LEGISLATIVE SESSION – ESTIMATES NOTE

- Advice/Recommentations ection 18.1 expands the current prohibition against approved facilities charging for medically necessary diagnostic services that are benefits under the MPA or the *Hospital Insurance Act* to include unapproved facilities. Advice/Recommentations Advice/Recommentations

FINANCIAL IMPLICATIONS

- If BC is subject to a CHT deducing in the amount reported in this filing, BC will have been assessed:

Fiscal Year	Payment Date	Total Penalties Assessed Since Mar -18	Total Reimbursement to Mar-20	Total Reimbursement to Mar-21	Total Reimbursement to Mar-22	Total Reimbursement to Mar-23	Net Penalties Assessed Since Mar-18
2020/21		23,110,530.54				(13,933,354.00)	9,177,176.54
2019/20	22-Mar	13,275,823.00			(11,948,241.00)		1,327,582.00
2018/19	21-Mar	13,949,979.00		(9,188,971.00)	(4,284,907.00)		476,101.00
2017/18	20-Mar	16,753,833.00		(11,992,825.00)	(4,284,907.00)		476,101.00
2016/17	19-Mar	16,177,259.00	(8,088,630.00)	(3,327,622.00)			4,761,007.00
2015/16	18-Mar	15,861,818.00	(7,930,909.00)				7,930,909.00
Totals		**99,129,242.54**	**(16,019,539.00)**	**(24,509,418.00)**	**(20,518,055.00)**	-	**24,148,876.54**

- In 2020/21 BC health authorities paid $33.5 million in contracts with private clinics to provide beneficiary services and increase access. These contracts require that partner clinics do not engage in extra-billing of any kind.
- Reports to Health Canada on extra billing and user charges in respect of medically necessary diagnostic services began in this year's report in December 2022 with a total of $17,165,309 of extra-billing reported.
- As a result of BC's corrective actions to eliminate extra-billing and user charges, in March 2023, Health Canada issued BC a $13,933,354 reimbursement for the 2020/21 CHT deductions.

KEY BACKGROUND

- Each year, BC is required to submit a report to HC, quantifying the total extra-billings for a prior fiscal year. HC assesses CHT penalties based on the reported extra-billings, and federal funding is reduced in the following fiscal year as a CHA compliance deduction.
- In October 2018, the enforceability of the Bill 92 provisions of the MPA was challenged in Court in Cambie Surgeries Corporate v. British Columbia (Attorney General).
- BC's Health Authorities contracted with 8 private surgical clinics and their medical practitioners to only provide contracted surgical services, bringing private surgical services back into the public system. In 2021/22 there were 16,777 contracted surgical cases.
- On September 10, 2020, the Honourable Mr. Justice Steeves delivered his reasons for judgement in the Cambie trial. The decision ruled in the Province's favour on all counts; all sections of the MPA being challenged were upheld. Cambie promptly appealed the decision.
- In October 2020, following the trial decision, Cambie applied to the Court of Appeal for a new injunction that would continue to prohibit the Province from enforcing certain provisions of the MPA until such time as the appeal was heard.
- On December 8, 2020, Justice Hunter of the Court of Appeal issued a limited form of injunction which prohibited the Medical Services Commission (MSC) from taking action against clinics or physicians in connection with private-pay surgeries where the patients' surgery had been scheduled in the public system for a date beyond the Ministry wait time benchmarks, or where a surgery had not taken place in the public system by the date set according to such wait time benchmarks. This injunction was originally in effect from December 8, 2020, until June 18, 2021. On July 6, 2021, the injunction was further extended until September 30, 2021.
- On July 15, 2022 BC Court of Appeal dismissed Cambie's appeal, upholding the original judgement.
- On April 1, 2020, the Federal Diagnostics Services Policy came into effect. This policy aims to ensure patients do not face charges for medically necessary diagnostic services such as (but not limited to) magnetic resonance imaging (MRI) and computed tomography (CT) scans, regardless of where the services are

provided. As of April 1, 2020, any province that has not eliminated patient charges for medically necessary diagnostic scans is subject to mandatory deductions under the terms of the *Canada Health Act*.

Audit Activity

- Audits identify the extent of patient charges by physicians and private clinics for insured health services in BC. Audits of private clinics assess compliance with the principles set out in sections 18 and 19 of the CHA, and more specifically sections 17 and 18 of the MPA with respect to extra-billing.
- The MSC approved 8 audit reports since October 2018, with audit periods ranging from 2015/16 to 2019/20. For these facilities, the MSC issued final audit reports accompanied by a letter from the MSC Chair. No recovery is expected.
- In August 2021 the Billing Integrity Program conducted an audit of Cambie's compliance with the Injunction Order. The audit report was submitted to the MSC in January 2022.
- The Billing Integrity Program completed 2 of the 3 remaining extra-billing audits as part of the initial reporting requirements to HC. These audit reports were approved by the Audit and Inspection Committee (AIC) on September 14, 2022 for recommendation to the MSC. The third extra-billing audit is in progress.
- An audit plan for diagnostic facilities has been developed Advice/Recommentations

Advice/Recommentations

- Advice/Recommentations

CHT Penalties

Amounts reported to HC on extra-billing and/or user charges, and corresponding federal deductions were:

Fiscal Year	Reported Patient Charges	Result of Onsite Audits	Charges related to medically necessary diagnostic services	Additional Health Canada Assessment*	Total
2020/21	$157	$5,945,064.04**	$17,165,309		$23,110,530.54
2019/20	$95	$13,275,728			$13,275,823
2018/19	$200	$13,949,779			$13,949,979
2017/18	$1,561	$16,752,272			$16,753,833
2016/17	$7,533	$16,169,726			$16,177,259
2015/16	$1,980	$592,173		$174,493	$768,646
2014/15	$10,015			$174,493	$184,508
2013/14	$29,652			$174,493	$204,145
2012/13	$67,144			$174,493	$241,637
2011/12	$50,075			$174,493	$224,568
2010/11	$105,526			$174,493	$280,019

* Based on specific findings in Cambie.

**includes $70,640.94 in charges found to be non-compliant with the Cambie Injunction

Relevant Legislation

- The CHA explicitly prohibits user fees and extra-billing of patients for insured services.
- Sections 17 and 18 of BC's MPA prohibit enrolled physicians from charging patients for Medical Service Plan insured services, as outlined in the MPA's Payment Schedule.
- Under the MPA, the Ministry has authority to audit enrolled physicians. The Ministry delegates this authority to the MSC.
- The AIC approves audit referrals based on delegated authority from the MSC. Approved audits are conducted by the Billing Integrity Program within the Ministry's Audit and Investigations Branch. Completed audit reports are presented to the AIC which provides recommendations and forwards the reports to the MSC for approval.

LEGISLATIVE SESSION – ESTIMATES NOTE

Release of Information - This information may be disclosed to the public.

LAST UPDATED

The content of this fact sheet is current as of April 4, 2023 as confirmed by Anne Schuetze.

APPROVALS

2023 03 31 - Kristy Anderson, Hospital & Provincial Health Services Division
2023 04 04 - Anne Schuetze, Finance and Corporate Services Division
2023 04 07 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Authority – Executives and Compensation

Topic: Public sector employers are required to disclose annually all compensation paid to the Chief Executive Officer (CEO) and the next 4 highest ranking or paid executives with decision-making authority.

Key Messaging and Recommended Response:

- **As part of Public Accounts the Public Sector Employers' Council Secretariat releases executive compensation for health authorities and Providence Health Care.**
- **Our objective is to ensure total compensation paid to senior executives is fair, and there is accountability and transparency for the public.**

CURRENT SITUATION

- The 2021/22 Executive Disclosure Statements for each health authority and Providence Health Care were posted by the Public Sector Employers' Council Secretariat (PSEC) and each of the health organizations in conjunction with the release of the Public Accounts and Service Plan Reports.
- The disclosure statements provide the base salary, employer contributions for statutory, pension, and health benefits and any other personal benefits provided, such as severance and sick leave payouts at retirement or conclusion of employment and vacation payouts. The objective is to disclose everything that a reasonable person would view as compensation.

FINANCIAL IMPLICATIONS

Appendix A is a summary of the information that was made public with the release of the province's Public Accounts.

KEY BACKGROUND

- As part of the BC government's economic recovery plan, the Minister of Finance determined that employers subject to compensation plans under the Public Sector Employers Act will be required to amend their Compensation Reference Plans (CRPs) to indicate that there will be no performance increases or adjustments paid to executive-level employees for the 2020/21 performance year.
- In 2016, under Phase 2 of the BC Public Sector Compensation Review, employers received approval to adjust executive and excluded management compensation within approved ranges.
- In 2015, under Phase 1 of the BC Public Sector Compensation Review, compensation reference plans and benchmarking were revised to ensure alignment with a common public sector compensation philosophy.
- In 2014, under the BC Public Sector Compensation Review, Government adopted a common public sector compensation philosophy, implemented new taxpayer accountability principles, and revised disclosure guidelines to further clarify and enhance transparency.
- In 2007/2008, the Public Sector Employers Act was amended requiring the disclosure of the salaries of public sector CEOs and the next 4 highest-ranking executives earning $125,000 or more in base pay.
- In 2002, the Public Sector Employers Act (Bill 66) was introduced, which required Ministerial approval of compensation plans, strengthened standards for severance payments, accumulated sick leave and vacation payouts.
- The Public Sector Employers Act requires that current contracts of senior executives be filed with the PSEC and available to the public.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of April 14, 2023 as confirmed by Peter Klotz, Executive Director, Regional Grants - Decision Support.

APPROVALS

2023-04-14 - Peter Klotz, Regional Grants - Decision Support
2023-04-14 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

APPENDIX A

Name	Principle Position	Base Salary	Pension	Benefits	All Other Comp	Total 2021/22	Total 2020/21	Total 2019/20
Fraser Health								
Lee, Dr. Victoria	President & CEO	$350,571	$34,229	$24,797	$415	$410,012	$406,144	$397,807
Brodkin, Elizabeth	VP, Population Health & CMHO	$287,840	$28,104	$24,098	$13,405	$353,447	$330,683	$0
Belle, Dr. Ralph	VP, Medicine	$287,840	$28,104	$21,901	$383	$338,228	$271,531	$0
Leith, Laurie	VP, Community Hospitals and Programs	$254,729	$24,871	$19,987	$489	$300,076	$298,982	$293,334
Dempster, Linda	VP, Patient Experience	$246,656	$0	$19,293	$352	$266,301	$0	$258,057
Interior Health								
Brown, Susan	President & CEO	$341,925	$34,611	$30,566	$34,343	$441,445	$420,255	$417,684
Pollock, Sue	CMHO	$269,118	$30,032	$20,660	$57,604	$377,414	$0	$0
De Villiers, Albert S	CMHO (Projects)	$189,958	$27,267	$22,860	$116,653	$356,738	$205,636	$0
Ertel, Mike	VP, Medicine & Quality	$280,947	$28,553	$26,947	$14,072	$350,519	$343,379	$334,967
Lommer, Donna	VP, Clinical and Corporate Services	$255,739	$26,230	$26,129	$17,712	$325,810	$315,039	$313,182
Letwin, Shallen	VP Clinical Operations, IH South	$259,096	$25,662	$25,536	$5,350	$315,644	$310,048	$278,578
Northern Health								
Ulrich, Catherine	President & CEO	$355,448	$35,012	$15,568	$878	$406,906	$390,771	$381,566
Chapman, Dr. Ronald	VP, Medicine	$309,197	$30,046	$16,365	$0	$355,608	$342,788	$347,834
Kim, Dr. Jong Woan	CMHO	$304,440	$31,602	$12,632	$0	$348,674	$320,919	$0
Anguish, Penny	COO, NI HSDA	$255,616	$24,839	$16,409	$884	$297,748	$286,008	$280,862
De Croos, Mark	VP, Financial & Corporate Services/CFO	$234,495	$22,787	$16,658	$0	$273,940	$263,340	$258,948
Providence Health Care								
Dalton, Fiona	President & CEO	$335,115	$32,720	$13,713	$0	$381,548	$393,132	$370,303
Simmers, Brian	CFO & VP, People & Health Informatics	$287,177	$28,033	$16,870	$6,066	$338,146	$313,649	$301,801
Ingram, David	VP, Major Capital Projects	$274,080	$26,747	$22,004	$6,043	$328,874	$0	$0
Carere, Ron	VP, Medical Affairs	$262,500	$0	$0	$0	$262,500	$262,500	$263,605
De Bono, Christopher	VP Mission, Org Dev & Ethics (last day: Nov 3, 2021)	$145,065	$14,978	$4,854	$16,030	$180,927	$271,717	$260,414
Heppell, Leanne	VP, COO Acute & Chief Professional Practice & Nursing	$98,008	$9,703	$3,322	$2,243	$113,276	$327,723	$286,989
Provincial Health Services								
Byres, David	President & CEO (effective Feb 9, 2021)	$177,500	$17,017	$20,166	$6,328	$221,011	$47,431	$0
Gustafson, Reka	VP, Public Health & Deputy Officer	$299,784	$32,505	$16,248	$115,333	$463,870	$0	$0
Wannamaker, Susan	Executive VP, Clinical Service Delivery (effective Jun 2019)	$309,973	$0	$15,015	$17,221	$342,209	$313,292	$309,209
MacNair, Scott	Executive VP Business Operations	$295,961	$28,869	$16,021	$0	$340,851	$132,588	$0
Quirk, Ronald	Executive VP, Digital Information Services & Innovation	$303,893	$11,228	$16,094	$5,038	$336,253	$337,392	$0
Vancouver Coastal Health								
Eliopoulos, Vivian	President & CEO	$362,057	$0	$16,726	$12,248	$391,031	$337,242	$304,580
Daly, Patricia	VP, Public Health and CMHO	$294,920	$28,813	$16,933	$46,827	$387,493	$356,056	$339,215
Pica, Fernando	CFO & VP, Strategic Business Services	$323,944	$31,649	$17,539	$3,600	$376,732	$360,075	$0
Sparks, Brett	VP, People	$175,159	$24,345	$17,235	$77,643	$294,382	$293,500	$0
Chittock, Dean	VP, Medicine, and Quality and Safety	$283,041	$0	$0	$0	$283,041	$183,750	$0
Balshin, Wayne	Acting VP, People	$193,965	$18,916	$18,413	$10,579	$241,873	$0	$0
Vancouver Island Health								
MacNeil, Kathryn E	President & CEO	$345,150	$33,647	$18,994	$6,000	$403,791	$405,088	$399,980
Stanwick, Dr. Richard	VP, Population Health & Public Health & CMHO	$313,379	$0	$2,948	$59,900	$376,227	$0	$0
Williams, Dr. Ben	VP Medicine and Quality & Chief Medical Executive	$270,896	$28,408	$20,632	$14,321	$334,257	$321,497	$0
Kerrone, Kim	VP & CFO	$273,078	$26,621	$16,361	$18,025	$334,085	$321,700	$338,702
Bjarnason, Lilja Elin	VP, Clinical Operations, South Island	$253,793	$24,741	$20,225	$7,431	$306,190	$304,706	$299,017
Hanson, James	VP, Clinical Operations, Central/North	$243,009	$23,690	$18,576	$20,079	$305,354	$0	$0
Damstetter, Cheryl N	VP, Priority Populations and Initiatives (last day: Dec 31, 2021)	$197,145	$19,524	$6,270	$7,827	$230,766	$288,071	$286,310

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Authority - Northern Health – Calls for Audit

Topic: The Ministry of Health (HLTH) has received multiple requests for performance audits of the Northern Health Authority (NHA), including capital costs.

Key Messaging and Recommended Response:

- **Over the past five years, Government has made significant investments across the health system in Northern BC.**
- **There have been numerous initiatives to address Health Human Resource (HHR) issues, including the development of a provincial HHR strategy.**
- **In addition, we have invested $6.4M for programs and incentives to encourage more health workers to move to and stay in the Northern Health Region, which includes supports for clinical management, virtual services, housing, childcare, travel, and a comprehensive Prototype Rural Retention Incentive Program.**
- **The funding also includes approximately $3M for financial incentives and support for priority health-care workers and further projects through partnerships between NHA and the Province.**

Government Financial Information

- **Significant investments have also been made on the capital side to update or replace aging hospital infrastructure in the North including:**
- **$ 27.0 million - G.R. Baker Memorial Hospital – ED and ICU Redevelopment (Quesnel) – announced April 2019 and opening on April 14, 2023.**
- **$632.6 million - Mills Memorial Hospital Replacement (Terrace) – announced April 2019, currently under construction and expected to open in early 2025.**
- **$158.3 million - Stuart Lake Hospital Replacement (Fort St James) – announced January 2020, currently under construction and expected to open in late 2024.**
- **$377.9 million - Dawson Creek & District Hospital Redevelopment – announced September 2020, currently in procurement and expected to start construction in spring 2023.**
- **As discussed in the 2022 Estimates debates for HLTH, the ministry does not feel an audit of NHA's operations is warranted or wise at this time as the pandemic**

response has affected health services and, as such, is not a reasonable example of ongoing health services.

CURRENT SITUATION

- The Province has increased investments over the past 5 years to improve health services in the Northern Health Region.
- There are significant global challenges to health human resources (HHR), which has been increased by the Pandemic, and disproportionally affects rural and remote communities in the Northern Health Region.
- HLTH has developed an overarching provincial HHR strategy for government consideration.

FINANCIAL IMPLICATIONS

Operating Budget Growth

- Government Financial Information

- In the previous 5 years, the NHA budget increased by $135.70 million (20%) from $674.3 million in 2011/12 to $810.00 million in 2016/17.

KEY BACKGROUND

Capital Projects/Investments since 2017

- Government has approved business plans for 4 major capital projects in the North since 2017:
  - $27.0 million - G.R. Baker Memorial Hospital – ED and ICU Redevelopment (Quesnel)
  - $632.6 million - Mills Memorial Hospital Replacement (Terrace)
  - $158.3 million - Stuart Lake Hospital Replacement (Fort St James)
  - $377.9 million - Dawson Creek & District Hospital Redevelopment
- G.R. Baker, Mills Memorial and Stuart Lake are in construction. Dawson Creek is expected to start construction in summer 2023.
- Government also approved the concept plan for a new acute care tower at University Hospital of Northern BC (UHNBC) in Prince George. Advice/Recommentations; Cabinet Confidences

Advice/Recommentations; Cabinet Confidences

- In addition to the major capital projects, investments totalling ~$185 million have been made in many smaller facility, equipment and IMIT projects across the North from 2017 to 2022. Examples include new MRI machines at Mills Memorial, Fort St. John and UHNBC and a CT scanner at Bulkley Valley Hospital in Smithers.

Investments in Northern Health Services since 2017

Primary Care

HLTH has provided a cumulative total of $18.52 million in additional funding from 2018/19 to 2021/22 and has allocated a budget of up to $12.22 million in 2022/23 to support 2 Urgent Primary Care Centres and the implementation of 11 Primary Care Networks which have had over 149,600[1] patient visits. Funding is provided to both NHA and the Division of Family Practice.

Specialized Community Services

- Mental Health and Substance Use (MHSU)
  - HLTH has provided additional funding of $93.42 million ($39.99 million in 2022/23) to support MHSU services such as increasing the number of youth and adult treatment beds, implementing Integrated Child and Youth Teams, implement Youth Concurrent Disorder Clinicians, various responses to the opioid crisis and other mental health services.

[1] Northern Health Authority UPCC Period Visit Reports: October 2018 to January 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

- Services for Older Adults
  - HLTH has provided additional funding of $57.21 million ($11.07 million in 2022/23) to support services for older adults including Specialized Community Services for Seniors and Long-term Care.
  - HLTH has allocated additional funding of $20.21 million to support the Health Career Access Program. 366 of the 416 NHA allocated seats have been filled.
- Hospital Services
  - Advice/Recommentations

    Advice/Recommentations Government Financial Information

    Government Financial Information
  - Surgical Strategy
    - MRI exams increased by over 10,700 (169%) from 6,331 in 2016/17 to 17,059[2] in 2021/22.
    - Increased investments to address surgical waitlists across the Province with annual funding of $100 million beginning in 2019/20 and additional investments over the fiscal plans including: Budget 2021; $495 million, and Budget 2022; $303 million.
    - The Rural and Remote strategy announced in 2020 to add 7 ground ambulances to NHA and 5 additional air resources across the province[3].
- Health Human Resources
  - HLTH has provided additional funding of $6.38 million in 2021/22 and $16.51 million in 2022/23 to HHR issues, such as Rural Recruitment Incentives, Housing, Child Care, Clinical Management Supports, Obstetrical Care, Travel Resources, and Real Time Virtual Services, while the Provincial HHR Strategy is being completed.
  - Rural and Remote Nurse Recruitment and Retention
    - In 2018, the Office of the Auditor General undertook an independent audit of the recruitment and retention of rural and remote nurses in Northern BC.
    - NHA implemented each of the 9 recommendations resulting from the audit which included expanding affordable housing options, develop and implement new retention and recruiting programs, create and implement a more effective HHR plan, analyze and improve the distribution of nursing education programs and other improvements to hiring, and distribution and orientation of nurse employees.
  - Targeted Recruitment and Retention Programs / Incentives
    - Northern Health Travel Nurse Program - promotes flexibility for nurses and nurse coverage in rural and remote communities and has increased nurse FTEs over the last 12 months.
    - Multiple Incentive Programs - provides incentives through signing bonuses and additional financial supports for professional development such as: the Rural and Remote Nursing Incentives ($10,000 bonus), Northern Rural Critical Care incentive ($20,000 bonus), Laboratory Technologists Recruitment Incentive ($10,000 bonus), Diagnostic Imaging Professional Recruitment Incentive ($10,000 bonus).
  - Health Education Expansion
    - Budget 2021 provided $96 million over the fiscal plan to support health sector training.
    - Once the training expansions have been realized the NHA should see annual graduates of 12 Medical Laboratory Technologists, 10 Pharmacy Technicians, 28 Licensed Practical Nurses, and 40 Registered Nurses.
    - The Surgical Renewal Strategy includes funding to support tuition and education leave stipends (~$30,000 per employee) to train as Medical Device Reprocessing Technicians and perioperative and post-anesthetic nurses.
    - Additional physician training including an Emergency Medicine Training program in Prince George, a Northern Anesthesiology Residency Training Rotation program, and Trained Dermatologist in the North.

[2] Data source is HAMIS database.

[3] As per BC Government news release https://news.gov.bc.ca/releases/2020PREM0020-000725

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of March 17, 2023, as confirmed by Peter Klotz, Executive Director, Regional Grants and Decision support.

APPROVALS

2023 03 17 – Peter Klotz, Finance and Executive Support
2023 04 05 – Kirk Eaton, Finance and Corporate Services
2023 04 07 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health System Heat Dome Response

Topic: It is anticipated BC will continue to experience extreme hot weather events and increases in average temperature faster than the global average due to climate change.

Key Messaging and Recommended Response:

- **Government has taken several steps to improve public education, communication and services during heat events, including:**
  - **Launching the BC Heat Alert and Response System (BC HARS) in June 2022;**
  - **Releasing the PreparedBC Extreme Heat Preparedness Guide**
  - **Supporting First Nations and local authorities by creating a new extreme heat funding stream under the Community Emergency Preparedness Fund**
  - **Providing guidance and funds for local authorities to proactively open cooling centres.**
  - **Increasing the budget for BC Ambulance Service from $424M to $559M, which will help response times.**
- **During the summer of 2022, the BC HARS was utilized and the BC Health Effects of Anomalous Temperatures Coordinating Committee (BC HEAT) monitored health impacts and provided guidance/messaging.**
- **The BC Coroners Service has provided recommendations to Government to lessen the impacts of future heat events. The Ministry is working to understand what actions can be taken by the health system to better support British Columbians in future heat events**
  - **We are hoping to gain a better understanding of some of the policy options through a targeted engagement process with a wide variety of partners, including "vulnerable/susceptible" populations**
  - **Planning is currently underway for targeted feedback and engagement sessions with partner organizations to gain feedback on the use of the BC HARS for 2023**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- From June to September 2022, BC experienced 6 heat warnings and multiple record setting daily temperature highs, but did not experience any extreme heat emergencies (defined by BC HARS).
- Jul 25 to Aug 01, 2022, an extended heat event took place in much of the province, impacting 40 forecast regions. This event was anomalous and concerning from a public health perspective due to the length of the event (9 regions impacted for 8 days) and the abnormally high overnight temperatures.
- During Summer 2022, the BC HARS was utilized for the first time. The BC HEAT Coordinating Committee actively monitored the heat events that occurred and supported response efforts by providing expert guidance and facilitating coordinated standardized communications.
- Work is currently underway to perform targeted engagement with communities and organizations across that province that are involved in heat planning and response activities; with particular focus on those that work with heat-vulnerable and equity-denied populations. This feedback will be used to assess the effectiveness of the BC HARS, and provide a basis for future updates to the system.

FINANCIAL IMPLICATIONS

- Estimates of the financial impacts of the heat dome are anticipated to be released summer 2023.
- The previous major heat wave in BC was in 2009. It is estimated economic losses in agriculture and fisheries, combined with reduced productivity and additional energy costs, totalled approximately $120 million.
- As of June 2021, the budget for the ambulance service has gone from $424 million in 2017 to $559 million. The new services of BCEHS are detailed below.

KEY BACKGROUND

- As part of the Climate and Preparedness Adaptation Strategy, the Province has developed an extreme heat framework, which includes the BC HARS, to inform and improve response capacity.
- Three recommendations were made to several ministries, agencies, and authorities in the Extreme Heat and Human Mortality: A review of Heat-Related Deaths in BC in Summer 2021:
  1. Implement a co-ordinate provincial heat alert and response system (BC HARS)
  2. Identify and support populations most at risk of dying during extreme heat emergencies
  3. Implement extreme heat prevention and long-term risk mitigation strategies
- The Ministry is addressing several time-bound sub-recommendations; these include:
  - Being the lead agency to coordinate the response to public health impacts from extreme heat.
  - Adoption of the BC HARS as well as sharing it for local government review and adoption.
  - Coordination of a gap analysis/evaluation of the BC HARS.
  - Facilitating the identification and prioritization of specific clients for home visits and contact during an extreme heat emergency.
  - Collaborating with partners to develop and distribute public messaging on self-care and caring for vulnerable persons during a heat event that is linguistically and culturally appropriate.
  - Conducted an internal policy review into issuing cooling devices as possible medical equipment accessible to persons most at risk of dying during extreme heat. The policy review is being finalized for executive.
  - Engaging and consulting with vulnerable populations and local government emergency planners regarding HARS planning, review and evaluation at provincial, regional and local levels, in collaboration with provincial health authorities and the First Nations Health Authority.
- 2021 heat dome background:
  - In the Extreme Heat and Human Mortality: A review of Heat-Related Deaths in BC in Summer report, BC Coroners Service (BCCS) identified 619 heat-related deaths from the June 2021 heat dome. The highest number of deaths were recorded on June 29 and June 28, which were also the peak temperature days.
  - 911 calls doubled during the peak of the heat dome

  - Of the 619 people identified by the BCCS who died, 67% were over 70 years old, 56% lived alone, 61% were located in low-income neighbourhoods, 98% of deaths occurred indoors and most decedents were in homes without adequate cooling systems. Comorbidities with the strongest correlation are psychotic disorders, substance abuse, and diabetes.
  - BC Centre for Disease Control (BCCDC) findings show that in 8 days, from Jun 25 to Jul 2, 2021, there were 740 more deaths than would be expected and that those most materially and socially deprived and without surrounding green space were most impacted.
- The Ministry of Health's Emergency Management Unit and the BCCDC co-chair the BC HEAT Coordinating Committee, comprised of public health experts in all the health authorities. The impetus of this committee was to ensure public health coordination is in place by summer 2022. This was addressed by:
  - Developing the BC HARS: 2022 and defining the triggers of a 2 tier alert system.
  - The first HARS tier, heat warning, means temperatures are very hot, and there is a moderate public health risk. Historically, a heat warning will usually be issued 1 to 3 times in a summer.
  - The second tier of the HARS, an extreme heat emergency, means temperatures are dangerous and there is a very high public health risk. This would typically be issued 1 to 2 times per decade.
  - Identifying recommended public health actions when Environment and Climate Change Canada issue a heat warning and when the BC HEAT Committee declares an extreme heat emergency.
  - Providing public health messaging targeted to reduce heat-related illness and mortality.
- The Province has taken actions that include putting air conditioning in long-term care facilities, and BCEHS has added 125 new full-time paramedic positions in urban areas and 42 new dispatcher positions. BCEHS has also added 22 ambulances, and converted staffing at 24 ambulance stations from on-call to 24 hours a day, seven days a week coverage.

LAST UPDATED

The content of this fact sheet is current as of April 04, 2023, as confirmed by Jamie Galt.

APPROVALS

2023 04 04 – Sarah Patterson, Logistics Strategy, Finance and Corporate Services Division
2023 04 12 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Capital Budget 2023/24 to 2025/26

Topic: Ministry of Health funding for health authority (HA) capital projects under the current 3-year budget and fiscal plan.

Key Messaging and Recommended Response:

- **Our government is working to update and fix the services people rely on by building and modernizing hospitals around B.C.**
- **By investing in new and existing public health-care facilities, people will have even better access to care. These projects also create jobs and stimulate economic activity.**
- **Capital spending on infrastructure in the health sector will total $11.2 billion over the next three years – a record level of investment.**
- **These investments support new major construction projects and upgrading of health facilities, medical and diagnostic equipment, and IM/IT systems. Examples include:**
    - **New St. Paul's Hospital**
    - **Royal Columbian Hospital Redevelopment**
    - **Richmond Hospital Redevelopment**
    - **Burnaby Hospital Redevelopment Phase 1**
    - **Mills Memorial Hospital Replacement**
    - **Dawson Creek & District Hospital Replacement**
    - **Stuart Lake Hospital Replacement**
    - **Cariboo Memorial Hospital Redevelopment**
    - **Cowichan District Hospital Replacement**
    - **St. Vincent's Heather Long-term Care Home in Vancouver**
    - **Western Communities Long-term Care Home in Colwood**
- **These investments are supported by funding from the Province (78% of the total) as well as other sources (22% of the total), such as Regional Hospital Districts and Hospital Foundations.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

The current 3-year budget and fiscal plan has a total of $8,735 million in capital funding for HAs.

FINANCIAL IMPLICATIONS

- The Ministry provides HAs with Restricted Capital Grants (RCG) for major construction, equipment, and upgrading of existing health facilities over $100,000. This funding is provided through the Health Facilities sub vote of the Capital Funding Vote in Other Appropriations.
- Access to non-RCG capital debt was previously available for major Public Private Partnerships (P3).
- Under the current 3-year budget and fiscal plan, the Ministry's capital budget for HAs is:
- Under the current 3-year budget and fiscal plan, the Ministry's capital budget for HAs is:

Health Sector Capital Spending Budgets	Budget 2022	Budget 2023			Total 2023/24 to 2025/26	% of Total 2023/24 to 2025/26
$ Millions	2022/23	2023/24	2024/25	2025/26		

Government Financial Information

- The split of Restricted Capital grant funding between new Priority Investment projects and annual Routine Capital investment spend is:

Restricted Capital Grants $ Millions	2022/23	2023/24	2024/25	2025/26	Total 2023/24 to 2025/26	% of Total 2023/24 to 2025/26

Government Financial Information

Sources:

- Ministry Capital – 2022/23 – amounts as per Q3 21/22 capital submission to Ministry of Finance (FIN).
- Ministry Capital – 2023/24 to 2025/26 – amounts per Q3 22/23 capital submission to FIN.

KEY BACKGROUND

HAs obtain additional capital funding from own-source revenues, Regional Hospital Districts, Foundations, and Auxiliaries.

RCG Funding

- The current 3-year budget and fiscal plan includes funding for:
  - Hospital redevelopment and replacement projects.
  - New hospitals.
  - Investments in new and replacement medical and diagnostic equipment, such as MRI and CT machines.
  - Investments in information management and technology, such as Electronic Health Record systems and supporting infrastructure.
  - Investments in projects to reduce energy costs, demonstrate clean energy, and lower carbon emissions as part of the Carbon Neutral Capital Program.
  - Investments to address asset rehabilitation, upgrades, and renovations at various facilities across BC.
  - Renewal and expansion of long-term care facilities, and
  - Primary care networks.
- All major capital projects with a total capital cost of $50 million or more and an approved business plan are summarized in the "Over $50 million Table" in the quarterly financial reports released by the Ministry of Finance. Currently, there are 25 health capital projects included in the $50 million table contained in the Budget and Fiscal Plan 2023/24 – 2025/26, reflecting costs to December 31, 2022. As capital projects span

multiple fiscal years, not all the funding for these projects is included in the current 3-year budget and fiscal plan period.

Public Private Partnerships (P3)
No capital funding is forecast to be provided in 2023/24 or thereafter.

Non-RCG Capital Funding and Maintenance Allocation (for items <$100k)
The Ministry also provides funding from the operating budget to be used for minor construction, equipment, and capital upgrading costing less than $100,000, as well as capital maintenance. This funding is approximately $77 million per annum with some additional one-off funding provided for renal projects and faculty of medicine expenditure allocated each year.

LAST UPDATED

The content of this fact sheet is current as of March 10, 2023, as confirmed by Kirk Eaton, Executive Director, Capital Services Branch, Financial and Corporate Services Division.

APPROVALS

2023 04 05 - Kirk Eaton, Capital Services Branch, Finance and Corporate Services
2023 04 07 - Rob Byers, Financial and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Capital Funding for Long-Term Care Renewal and Expansion

Topic: Status update on Long-term Care (LTC) renewal and expansion.

Key Messaging and Recommended Response:

- **Investment in the renewal and expansion of health authority LTC facilities is a priority for the capital plan. The overriding objective is to replace outdated facilities and eliminate multi-bed rooms, while also adding to the supply of health authority-owned beds to help meet growing demand.**
- **To date, two project business plans have been approved as part of the LTC renewal and expansion initiative:**
    - **the St. Vincent's Heather Care Home in Vancouver, owned and operated by Providence Health Care (PHC); and**
    - **the Western Communities Care Home in Colwood, owned and operated by Vancouver Island Health Authority (VIHA).**

CURRENT SITUATION

- Health authorities are working on business plans for LTC projects to be funded from the LTC renewal and expansion capital funding envelope.
- The overriding objective is to replace outdated facilities and eliminate multi-bed rooms, while also adding to the supply of HA-owned beds to help meet growing demand.
- To date, 2 project business plans have been approved as part of the LTC renewal and expansion initiative: the St. Vincent's Heather Care Home in Vancouver, owned and operated by Providence Health Care (PHC); and the Western Communities Care Home in Colwood, owned and operated by Vancouver Island Health Authority (VIHA).

CONFIDENTIAL INFORMATION – NOT PUBLICLY DISCLOSED

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Table 1: Summary of Projects Pending Approval

TB Sub #	Project Location	Project Description	Total Project Cost	Provincial Funding
H22-03	Abbotsford	A new 200-bed facility including an adult day program with space for 32 clients and a child day care centre with space for 49 children. The project replaces the 109 beds at the existing outdated Cottage/Worthington facility on the FHA-owned Cottage lands (33457 Cottage Lane) and will result in 91 net new beds. The facility will be constructed at 1919 Jackson Street, following land exchange with the Maplewood Care Society for the Cottage lands plus financial compensation for the difference in the land value.	$211m Includes $22m for land	$157m
H22-05	Richmond	A new 144-bed facility including an adult day program with space for 25 clients and a child day care centre with space for 37 children. The project replaces the 86 beds currently located at the temporary Richmond Lions Manor (RLM)-Bridgeport facility and will add 58 new beds for a total of 144 beds. The new facility will be located at the original site of the RLM at 11771 Fentiman Place.	$178m	$178m
H22-09	Delta	A new 200-bed facility including an adult day program with space for 32 clients and a child daycare centre with space for 49 children. The project replaces the existing 92 beds at the Mountain View Manor in Delta and will result in 108 net new beds.		
H22-45	Campbell River	The Project includes an adult day program with space for 12 clients and a child daycare centre with space for 37 children.	$134m	$80m
		Subtotal		
		Already approved projects:		
		Total		

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

Advice/Recommentations; Cabinet Confidences; Government Financial Information

FINANCIAL IMPLICATIONS

The capital cost and funding sources of each project will be confirmed in the project business plans and announced after the Business Plans are approved.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

CONFIDENTIAL INFORMATION – NOT PUBLICLY DISCLOSED

Advice/Recommentations; Cabinet Confidences

Advice/Recommentations; Cabinet Confidences bringing the total amount of funding to just over $2 billion. Advice/Recommentations; Cabinet Confidences

Advice/Recommentations; Cabinet Confidences

LAST UPDATED

The content of this fact sheet is current as of March 22, 2023, as confirmed by Kirk Eaton, Executive Director, Capital Services Branch

APPROVALS

2023 04 06 - Kirk Eaton, Capital Services Branch, Finance and Corporate Services Division
2023 04 11 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Capital Expenditures

Topic: Status update on capital expenditures to support the COVID-19 pandemic response.

Key Messaging and Recommended Response:

- **$149.3 million in capital funding was allocated to help with the response to the COVID-19 pandemic.**
- **$134 million in Restricted Capital Grant (RCG) funding was provided to health authorities for a variety of initiatives.**
- **Of the $134 million, $112 million has been spent and $20.9 million is forecast to be spent in 2022/23 ($13.7 million) and 2023/24 ($7.2 million).**
- **The remaining $15.3 million was for Ministry IM/IT projects and funded from the Consolidated Revenue Fund (CRF).**

CURRENT SITUATION

- In September 2020, Treasury Board approved $149.25 million in additional capital expenditures for the Ministry of Health to help with the response to the COVID-19 pandemic.
- $133.95 million was allocated to health authorities for the initiatives summarized in Table 1.
- The remaining $15.3 million was for Ministry IM/IT projects. Expenses incurred for these projects in 2020/21 were funded from the Consolidated Revenue Fund (CRF) capital contingencies vote.

Table 1: Allocation of COVID-19 Capital Funding

	COVID 19 Capital	Approved Funding As per Letters						
	Initiative	FHA	IHA	NHA	PHSA	VCHA	VIHA	Total
1	Surgical Renewal	$ 5,000,000	$ 5,558,000	$ 4,100,000	$ -	$ 1,530,871	$ 5,600,000	$ 21,788,871
2	HAU, ICU Renovations	$ -	$ -	$ -	$ -	$ -	$ 9,832,527	$ 9,832,527
3	Beds & Stretchers	$ -	$ 5,819	$ 315,000	$ 8,182,998	$ 3,103,856	$ 689,744	$ 12,297,416
4	Ventilators	$ -	$ 604,500	$ 795,474	$ 7,041,149	$ 1,664,989	$ 224,049	$ 10,330,161
5	Monitors/Defibrillators	$ -	$ 77,537	$ 13,641	$ 9,365,666	$ 1,384,898	$ 327,540	$ 11,169,282
6	IM/IT Infrastructure (HA Capital)	$ 3,694,683	$ 900,000	$ 233,690	$ 10,442,188	$ 15,680	$ 3,262,534	$ 18,548,775
7	Lab Testing Equipment	$ 3,985,809	$ 3,775,008	$ 1,770,222	$ 12,447,879	$ 2,450,698	$ 591,653	$ 25,021,269
8	BCCDC Vaccine Warehouse Upgrades	$ -	$ -	$ -	$ 4,250,000	$ -		$ 4,250,000
9	Medical Imaging	$ 762,552	$ 350,000	$ -	$ -	$ 264,252	$ 635,268	$ 2,012,072
10	Ambulances	$ -	$ -	$ -	$ 12,426,709	$ -		$ 12,426,709
11	Other Equipment	$ 1,651,050	$ 1,102,631	$ 83,042	$ 1,621,720	$ 528,632	$ 1,286,713	$ 6,273,788
	HA Total	**$ 15,094,094**	**$ 12,373,495**	**$ 7,311,069**	**$ 65,778,309**	**$10,943,876**	**$22,450,028**	**$ 133,950,871**

FINANCIAL IMPLICATIONS

- Provincial capital funding totalling $88.14 million towards the cost of the COVID-19 initiatives in Table 1 was spent in 2020/21 by the health authorities, with a further $23.98m spent in 2021/22.
- Current forecasts for future spending are $13.73 million in 2022/23 and $7.16 million in 2023/24.
- The Ministry spent $8.36 million in 2020/21 for five Ministry IM/IT projects as part of its response to the COVID-19 pandemic and a further $3.76m in 2021/22 for COVID-19 Ministry IM/IT projects. Funding came from the CRF.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- On March 18, 2020, BC declared a Provincial State of Emergency to support the province-wide response to the COVID-19 pandemic - one day after the Provincial Health Officer declared a Public Health Emergency on March 17, 2020.
- From the outset, BC responded with clear guidance, transparency, and an evidence-based approach to fight against COVID-19.
- Health authorities, including the regional health authorities and the Provincial Health Services Authority and agencies, have responded to the pandemic in part by identifying required equipment and renovations to prepare for surges in demand for testing and patient care, and by supporting increased infection control requirements.
- The capital funding is mostly for renovations and equipment needed for the pandemic response, including:
    - Renovations to enable surge capacity in COVID-19 designated hospitals;
    - Equipment and renovations to support the Province's surgical strategy;
    - More physical beds and stretchers, ventilators, patient monitors, and defibrillators to address anticipated surges in bed requirements, provide acute capacity overflow, support critically ill patients, stock BC Emergency Health Services (BCEHS) vehicles, support remote monitoring, and enable enhanced infection control and limit transmission between patients;
    - Additional IM/IT infrastructure to support increasing data needs, virtual care, and support for contact tracing;
    - Lab testing equipment for BC Centre for Disease Control (BCCDC) and health authorities;
    - BCCDC warehouse upgrades and increased fridge capacity;
    - Additional medical imaging and imaging systems equipment, including portable and mobile equipment and systems to enable remote viewing; and,
    - Additional BCEHS capacity, including refurbishment/replacement of up to 55 ambulances to participate appropriately in the Rural Remote Framework, and to also be prepared for additional surge capacity in the event of a COVID-19 resurgence in the fall/winter.

LAST UPDATED

The content of this fact sheet is current as of March 20, 2023, as confirmed by Kirk Eaton, Executive Director, Capital Services Branch

APPROVALS

2023 04 06 - Kirk Eaton, Capital Services Branch, Finance and Corporate Services Division
2023 04 11 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION - ESTIMATES NOTE

New Regional Cancer Centres in Nanaimo and Kamloops

Topic: Status of planning for new regional cancer centres in Nanaimo and Kamloops.

Key Messaging and Recommended Response:

- **Planning is underway for a new cancer centre in Nanaimo and a new cancer centre in Kamloops. The planning is being led by BC Cancer, which is part of the Provincial Health Services Authority (PHSA), in collaboration with Island Health and Interior Health.**
- **The Business Plans are expected to be finalized in the fall of 2023. The detailed scope, schedule, budget, and procurement strategy will be confirmed in the Business Plans and announced after Government approval of the Business Plan.**

CURRENT SITUATION

- Business planning is underway for new cancer centres in Nanaimo and Kamloops.
- The planning is being led by the Provincial Health Services Authority (PHSA) and BC Cancer, in collaboration with Interior Health Authority (IHA) and Vancouver Island Health Authority (VIHA).
- The cancer centres will be located on the campuses of the Nanaimo Regional General Hospital (NRGH) and the Royal Inland Hospital (RIH) in Kamloops.
- The intent is to finalize the Business Plans and submit for Government approval in the fall of 2023.

CONFIDENTIAL – NOT PUBLICLY DISCLOSED

- The table below summarizes the preliminary scope of each project and the estimated total capital cost. The final scope, schedule, budget and procurement strategy will be confirmed in the Business plans.

Project	Preliminary Scope	Total Project Cost
Nanaimo Cancer Centre	Advice/Recommentations; Cabinet Confidences; Government Financial Information	

LEGISLATIVE SESSION - ESTIMATES NOTE

Project	Preliminary Scope	Total Project Cost
Kamloops Cancer Centre	**The new building** will provide space for: • Patient arrival and check-in. • Radiation treatment, including three shielded treatment rooms ("bunkers") for high energy radiation treatment Linear Accelerators (LINACS), Advice/Recommentations; Cabinet Confidences • Radiation therapy planning, including a CT Simulator. • An outpatient ambulatory care unit, including exam rooms and consult rooms. • Staff support, including offices and workstations. • A net new MRI machine. • Approximately 475 stalls as a part of an attached parkade. Advice/Recommentations; Cabinet Confidences	Advice/Recommentations; Cabinet Confidences; Government Financial Information

FINANCIAL IMPLICATIONS

The financial implications of the new regional cancer centres in Kamloops and Nanaimo will be confirmed in the project business plans.

KEY BACKGROUND

Government Commitments

- The NDP Platform released on October 6, 2020, commits to establishing a 10-year cancer care plan.
- At a campaign stop on October 7, 2020, in Vancouver, Premier Horgan committed to a 10-year cancer plan that includes new cancer centres at Nanaimo and Kamloops.
- An NDP Press Release on October 17, 2020, noted the NDP's commitment to deliver a new cancer centre in Kamloops as part of the 10-year cancer plan.
- The Minister of Health Mandate Letter, November 26, 2020, stipulated that the Minister of Health is to, "Make British Columbia a leader in the full continuum of cancer care by launching a 10-year Cancer Action Plan."

BC Cancer

- As a service of the Provincial Health Services Authority (PHSA), BC Cancer has a mandate to deliver a comprehensive range of specialized oncology care throughout British Columbia through regional cancer centres and through partnerships with Community Oncology Network (CON) sites and primary care providers.
- BC Cancer's mandate covers the spectrum of cancer care, from prevention and screening, to diagnosis, treatment, and rehabilitation and includes setting treatment standards, and conducting research into causes of, and cures for, cancer.

Existing Regional Cancer Centres

- Table 1 provides a summary of the existing six regional cancer centres, including the number of linear accelerators (LINACS), Positron Emission Tomography / Computed Tomography (PET/CT) machines, and cyclotrons (which produce radioisotopes used for the PET/CT scans) that are currently in operation.

Table 1: Summary of Existing Regional Cancer Centres

Cancer Centre	Host Hospital	Year Opened	# of LINACS	# of PET/CT Machines	Cyclotron on Site?
BC Cancer Vancouver	Vancouver General Hospital	1980	9	2	Yes
BC Cancer Surrey	Surrey Memorial Hospital	1995	5		No
BC Cancer Abbottsford	Abbotsford Regional Hospital	2008	4		No
BC Cancer Kelowna	Kelowna General Hospital	1998	5	1	No
BC Cancer Victoria	Royal Jubilee Hospital	2001	6	1	No
BC Cancer Prince George	University Hospital of Northern BC	2012	2		No

- In addition to the existing six regional cancer centres, a business plan has been approved for the New Surrey Hospital and Cancer Centre, and a concept plan has been approved for a new regional cancer centre in Burnaby as part of Phase 2 of the Burnaby Hospital Redevelopment.

LAST UPDATED

The content of this fact sheet is current as of March 22, 2023, as confirmed by Kirk Eaton, Executive Director, Capital Services Branch

APPROVALS

2023 03 22 – Kirk Eaton, Capital Services Branch
2023 04 11 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

New Surrey Hospital and BC Cancer Centre

Topic: Status and scope of the New Surrey Hospital and BC Cancer Centre project.

Key Messaging and Recommended Response:

- **The New Surrey Hospital and BC Cancer Centre project is currently in procurement, with approval of preferred proponent scheduled for end of June 2023.**
- **The project will increase capacity to improve access to services and help meet the needs of a growing and aging population, while reducing congestion and overflow pressures at Surrey Memorial Hospital and the Jim Pattison Outpatient Care & Surgery Centre, and providing a new BC Cancer centre for the residents of Surrey.**

CURRENT SITUATION

- The New Surrey Hospital and BC Cancer Centre (NSHBCCC) project is currently in Design-Build (DB) procurement, with approval of preferred proponent scheduled for end of June 2023.
- The NSHBCCC project, including scope of services, was planned through the detailed concept and business planning process, led by Fraser Health Authority (FHA) in partnership with BC Cancer and Provincial Health Services Authority (PHSA).
- The NSHBCCC project will increase capacity to improve access services and help meet the needs of a growing and aging population, while reducing congestion and overflow pressures at Surrey Memorial Hospital, Jim Pattison Outpatient Care & Surgery Centre and at BC Cancer - Surrey.
- The approved scope of the NSHBCCC project is an integrated community hospital and cancer centre of approximately 70,000 m^2 in size that includes:
    - Inpatient services with 168 acuity adaptable inpatient beds;
    - Virtual care throughout all clinical service areas;
    - Surgical/perioperative suite with four operating rooms, four procedure rooms and a brachytherapy suite;
    - Emergency department with 55 treatment spaces;
    - Outpatient ambulatory care with 27 exam rooms/chairs;
    - Medical imaging department, including three CT scanners, two MRI machines, six general radiology rooms, one bone density room, 5 mammography rooms, 4 echocardiogram rooms, and 6 ultrasound rooms;
    - Pharmacy, laboratory, academic spaces, and facility and clinical support services;
    - Dedicated area for spiritual care and family gatherings that support cultural diversity and spiritual practices;
    - New BC Cancer Centre with an oncology ambulatory care unit with 50 exam rooms; 54 chemotherapy treatment spaces; room for six linear accelerators for radiation therapy (5 equipped at opening); functional imaging, including 2 PET/CT machines and a new Cyclotron for production of radioisotopes; clinical trials unit, oncology pharmacy, and administrative space;
    - Parking of approximately 730 stalls;
    - 49 space Childcare Centre.
- The NSHBCCC project will support Government policy objectives, including: climate resilience and energy conservation measures; childcare spaces; and, labour objectives, including promoting apprentices in

construction, representation of underrepresented groups in construction and design, and Indigenous cultural and business opportunities.

FINANCIAL IMPLICATIONS

Cabinet Confidences; Government Financial Information

KEY BACKGROUND

- Expansion of health services in Surrey is needed to meet a rapidly growing and aging population and to help alleviate capacity constraints at existing facilities in Surrey.
- On December 18, 2017, the planning for a new hospital was announced in Surrey.
- On May 29, 2019, FHA submitted a Concept Plan for a New Surrey Hospital (the NSH) to the Ministry of Health.
- In July 2019, Treasury Board approved the Concept Plan for the NSH, and for FHA to proceed to business planning for a preferred site beside Kwantlen Polytechnic University (KPU) at 5500 180 Street in Cloverdale. This approval was announced on December 9, 2019 in Surrey.
- On June 17, 2020, Treasury Board approved the addition of an integrated cancer centre and rightsizing of the host hospital to the project scope.
- On November 30, 2020, the FHA submitted the NSHBCCC Business Plan to the Ministry of Health and to the FHA Capital Project Board, which provided oversight for the development of the Business Plan and will continue to oversee the project through to completion.
- Following the review and approvals process, Government approved the NSHBCCC business plan in March 2021.
- Government announced the issuing of a Release for Qualifications (RFQ) for the Project in November 2021. Two proponents were shortlisted in the RFQ process, which ended on March 17, 2022. The two proponents are EllisDon Design Build Inc. and PCL Construction Ltd.
- The Request for Proposals (RFP) was issued on June 30, 2022 to the two proponents. Advice/Recommentations

Advice/Recommentations

Advice/Recommentations Based on this schedule, the facility would be available for patients in November 2027. The schedule may change, based on the preferred proponent's construction schedule.

- Formal First Nations Consultation with the Katzie, Kwantlen and Semiahmoo First Nations (the KKS) on the land transfer for NSHBCCC from KPU to FHA took place between December 2019 and May 2022, when a final consultation close-out letter was issued to the KKS. Following approval of the land transfer by Ministry of Post-Secondary Education and Future Skills (PSFS) on June 24, 2022, KPU and FHA executed the purchase and sale agreement on January 9, 2023, with subject removal and closing expected to occur in May 2023.

LAST UPDATED

The content of this fact sheet is current as of March 24, 2023, as confirmed by Kirk Eaton, Executive Director, Capital Services.

APPROVALS

2023 03 24 – Kirk Eaton, Capital Services, Finance and Corporate Services Division
2023 04 11 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Home and Community Care Temporary Rate Reductions (Hardship Waivers)[1]

Topic:

- A revised Temporary Rate Reduction (TRR) process was implemented on April 1, 2013, in response to recommendations in the Ombudsperson's 2012 report, *"The Best of Care: Getting it Right for Seniors in BC (Part 2)."*
- The Ministry of Health committed to monitoring TRR numbers under the revised process for a period of 2 years starting July 1, 2013. At the completion of the 2 years, the Ministry and the 5 regional health authorities (HAs) committed to ongoing monitoring.

Key Messaging and Recommended Response:

- **We know that financial hardship can affect anyone at any time, and can be difficult for people receiving publicly subsidized home and community care services.**
- **Starting in 2013, at the recommendation of the Ombudsperson, health authorities created a process for clients to request rate reductions.**
- **The number of rate reduction applications have dropped slightly since 2019/20 from 2,903 to 2,446 in 2021/22 – only 54 applications were rejected in 2021/22 and up to December 31, 2022 only 33 were.**

CURRENT SITUATION

- A TRR is a time-limited, reduced rate for clients receiving publicly subsidized home and community care services, who would experience serious financial hardship if they were to pay their assessed client rate.
- There are 4 Ministry-authorized, standardized TRR forms, one for each of long-term care, assisted living, home support and short-stay services. HAs calculate a temporary reduced rate based on the client's and spouse's (if applicable) income and the essential expenses based on family size. If approved, the client may pay a nil or reduced client rate.
- Effective April 1, 2013, changes to the TRR process were made to ensure the process reflected the cost of living in BC at that time. These changes resulted in updates to the types of allowable expenses that could be claimed, given the necessary supporting documentation is provided. A TRR process was added for the calculation of the temporary daily rate for home support clients, to ensure the client's expenses are considered fair and consistent for the service area.
- TRRs can be approved for up to a maximum of 12 months. HAs can authorize a new TRR of the assessed client rate if a client or their family will continue to experience serious financial hardship by paying the assessed client rate when their current reduced rate is expired.
- In response to a recommendation by the Office of the Ombudsperson, HAs have been collecting and reporting data to the Ministry on the number of TRR applications approved/denied and the number of TRR policy exceptions.

[1] The data source for the information referenced in this fact sheet is the TRR quarterly data reporting submitted by the five regional health authorities to the Ministry of Health. Not applicable to Provincial Health Services Authority (PHSA) and First Nations Health Authority (FNHA), as they do not grant TRRs.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The number of TRR applications approved province-wide in each quarter[2,3]:

Fiscal Year	Quarter				Total
	Q1	Q2	Q3	Q4	
2019/20	791	630	737	745	2,903
2020/21	573	611	745	895	2,824
2021/22	718	552	476	700	2,446
2022/23	601	483	381	-	1,465
Most recent four quarters (Jan 2022 to Dec 2022)					2,165

- The number of TRR approvals over the period January 1, 2021, to December 31, 2022, per HA[4]:

		Interior	Fraser	Vancouver Coastal	Island	Northern	Total
January 1, 2021, to December 31, 2021	Total Number of TRR approvals by HA	1,409	326	288	492	126	2,641
	Percent of Total	53%	12%	11%	19%	5%	100%
January 1, 2022, to December 31, 2022	Total Number of TRR approvals by HA	923	313	303	492	134	2,165
	Percent of Total	43%	14%	14%	23%	6%	100%

- The number of TRR denials is low, as TRR applications are generally submitted only when HAs know the application will most likely be approved. From January 1, 2021, to December 31, 2021, there was a cumulative total of 54 TRR applications denied, and 33 were denied between January 1, 2022, and December 31, 2022[5]. Most TRR approvals are for long-term care services. TRR approvals are based on type of service[6]:

		Long-Term Care	Assisted Living	Home Support	Short-Stay	Total
January 1, 2021, to December 31, 2021	Total Number of TRR approvals	881	157	825	778	2,641
	Percent of Total	33%	6%	31%	29%	100%
January 1, 2022, to December 31, 2022	Total Number of TCC approvals	718	144	688	615	2,165
	Percent of Total	33%	7%	32%	28%	100%

[2] Numbers presented in this factsheet should be interpreted with caution due to the possible variations in data collection or reporting methods used by the health authorities.
[3] 3000_0076 HCC Q3 - Temporary Rate Reduction Report April 1, 2019, to – December 31, 2022.
[4] Ibid.
[5] Ibid.
[6] Ibid.

- 73% of all exceptions to TRR policy are for administrative reasons: Non-standard income documentation, incomplete expense documentation, or an adjustment of the effective date of the TRR[7].

		Ineligible clients (e.g., MSD client)	Non-Standard Income Docs.	Incomplete Expense Docs.	Adjusted effective date	Other	Total
January 1, 2021, to December 31, 2021	Exceptions to TRR policy (all HAs combined)	5	257	291	178	381	1,112
	Percent of Total	0%	23%	26%	16%	34%	100%
January 1, 2022, to December 31, 2022	Exceptions to TRR policy (all HAs combined)	8	200	122	203	185	718
	Percent of Total	1%	28%	17%	28%	26%	100%

LAST UPDATED

The content of this fact sheet is current as of February 10, 2023, as confirmed by Christine Voggenreiter.

APPROVALS

2023 02 21 - Christine Voggenreiter, Health Sector Information, Analysis & Reporting Division
2023 02 28 - Martin Wright, Health Sector Information, Analysis & Reporting Division

[7] Ibid.

LEGISLATIVE SESSION – ESTIMATES NOTE

Measure of Attachment to a Primary Care Provider

Topic: "Attachment" describes an ongoing care relationship between a primary care provider and a patient. The relative size of the unattached population is an indicator of the need for primary care resources.

Key Messaging and Recommended Response:

- **Measuring attachment to a primary care provider has traditionally relied on the Ministry's internal algorithm and the Canadian Institute of Health Information.**
- **To improve our ability to measure attachment, we have introduced new infrastructure in support of our Primary Care Strategy.**
- **Health Connect Registry (HCR) implementation: The HCR centralizes and streamlines registration for primary care providers, helping close the patient-provider gap in communities.**
- **Information collected in the HCR provides real-time data on the patient-to-provider gap in communities and inform health system planning and primary care recruitment efforts across the province.**

CURRENT SITUATION

- The Ministry of Health has historically relied on two measures to estimate patient attachment:
  - The Ministry's attachment algorithm (provincial and community level estimates).
  - Canadian Community Health Survey data (Statistics Canada survey).
- Additional measures are being used to estimate need and track the progress of the Ministry's Primary Care Strategy.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Current/Historical Attachment Measures

The Attachment Algorithm

- The algorithm is derived from Medical Services Plan (MSP) data on patterns of primary care use. It has the advantage of using administrative data to generate a full-system view of how patients access primary care.
- The algorithm does not provide any information on how patients and providers view their care relationship (e.g., if the patient views the provider they are attached to under the algorithm as 'their' provider).
- Patients may be categorized as attached, unattached, or unknown.
  - A patient is categorized as **attached** if: The majority of a minimum of 5 primary care visits in (up to) the last 10 years were made to the same primary care provider or group practice, or a patient does not have 5 visits but has 3 visits to the same practice/provider.
  - A patient is categorized as **unattached** if the patient has the minimum 5 visits in up to 10 years but does not have a majority with a primary care practice/provider.

  - A patient is categorized as **unknown** if the patient does not have the minimum 5 visits in up to 10 years and does not have 3 visits to the same practice.
- Attachment to an individual provider is also calculated, although attachment to a group/solo practice is the measure most commonly used because it better reflects the reality of primary care delivery; a patient may have a primary care provider but may not see the same provider each time they visit the practice.
- The unattached grouping is the population of focus; these are patients who use primary care, but who do not seem to have a longitudinal relationship with a provider.
- The unknown population uses very little primary care and is similar in magnitude to the percent of BC residents who say they are not looking for a provider in the Canadian Community Health Survey.
- Table 2 illustrates recent attachment rates as estimated by the algorithm. Note that 2020/21 and 2021/22 estimates are lower but may have been impacted by the pandemic.
- Compared to the over all population, the unattached population tends to be:
  - More male: 55.6%, compared to 47.2% of the attached and 49.5% of the total populations.
  - Younger: average age of the unattached is 33, compared to 46 in the attached and 43 overall.

Statistics Canada's Annual Canadian Community Health Survey (CCHS)

- The CCHS provides a patient perspective on attachment that is unavailable in the attachment algorithm calculation and been frequently used in Ministry communications.
- Estimates are reported at the provincial level but are a useful comparator to the estimate produced by the algorithm.
- Because it is a survey, CCHS results are dependent on resident responses from a representative sample of British Columbians.

Table 1. Canadian Community Health Survey Results

Year	Percent with regular provider	Percent with no regular provider	Percent seeking provider	BC population	Estimated number seeking provider
2021	83.0%	17.0%	10.1%	5,194,137	524,608
2020	80.9%	19.1%	11.1%	5,139,568	569,361

Table 1. CCHS estimates of BC residents seeking provider[1]

Year	Percent with regular provider	Percent with no regular provider	Percent seeking provider	BC population	Estimated number seeking provider
2021	83.0%	17.0%	10.1%	5,194,137	524,608
2020	80.9%	19.1%	11.1%	5,139,568	569,361

Table 1. CCHS estimates of BC residents seeking provider[2]

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2021	83.0%	17.0%	10.1%	5,194,137	524,608
2020	80.9%	19.1%	11.1%	5,139,568	569,361

Health Connect Registry

- The Health Connect Registry (HCR) is being implemented across Primary Care Network (PCN) communities as a centralized and streamlined process for individuals, their families, or persons in their care to register for a primary care provider, family doctor or nurse practitioner. Registration is available online at HealthLinkBC.ca or by phone at 8-1-1 for those who require additional supports or translation.

[1] Statistics Canada. Table 13-10-0096-01 Health characteristics, annual estimates
[2] Statistics Canada. Table 13-10-0096-01 Health characteristics, annual estimates

- Information collected in the HCR will provide real-time data on the patient to provider gap in communities and inform health system planning and primary care recruitment efforts across the province.

On-Going Monitoring of Attachment

- This is being addressed by the introduction of a $0 fee item for practitioners to enter into the MSP claims system when they meet with a patient and agree to take that patient on their panel.
- This fee item will allow reporting on a given PCN's progress toward its attachment target to begin earlier than the attachment algorithm which relies on historical data.
- As of January 5, 2023, 263,917 people have been attached through Primary Care Strategy initiatives.

Capacity Gap Analysis

- The capacity gap analysis was developed to assist PCN communities with service planning by focusing on primary care needs in local areas.
- The capacity gap analysis identifies a target population to be attached in the community by:
    - Estimating the current primary care workforce and its capacity to provide care in a geographic area,
    - Estimating the population in need of primary care within that area,
    - Identifying a gap (if any) between the population needs and workforce capacity.
- The capacity gap analysis is developed in collaboration with PCN planners and uses local information. Community partnership helps obtain a more accurate picture of local circumstances:
    - Where available, the capacity gap analysis uses data provided by the community on the primary care workforce. This helps identify practitioners working in the community, which may differ from Ministry data, where practitioner location is recorded by their billing address. A practitioner's billing address may not be the same as their practice location.

Table 2. Attachment Algorithm Patient Attachment Status for Last 5 Fiscal Years[3]

	Attached		Unattached		Unknown	
Fiscal Year	Residents	Percent	Residents	Percent	Residents	Percent
2021/22	4,220,504	77.2%	663,598	12.1%	585,088	10.7%
2020/21	4,112,271	77.3%	686,773	12.9%	520,335	9.8%
2019/20	3,961,570	75.4%	774,581	14.7%	515,672	9.8%
2018/19	3,867,075	75.3%	799,255	15.6%	467,745	9.1%
2017/18	3,819,472	75.9%	777,696	15.4%	437,334	8.7%

LAST UPDATED

The content of this fact sheet is current as of February 20, 2023, as confirmed by Eric Larson.

APPROVALS

2023 02 20 – Eric Larson, Health Sector Information, Analysis & Reporting Division
2023 04 18 – Martin Wright, Health Sector Information, Analysis & Reporting Division

[3] Ministry of Health, Health Sector Information, Analysis, & Reporting Division, Client Roster Database, Extracted February 13th, 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

Mental Health and Substance Use Beds Overview

Topic: In BC, people with Mental Health and Substance Use (MHSU) conditions may access an array of health services, including bed-based services provided in community (and supported housing), acute, tertiary, and emergency department facilities. The Ministry of Health collects data on the Ministry's funded MHSU beds/units and rooms on a quarterly basis through the MHSU Bed Survey.

Key Messaging and Recommended Response:

- **Treatment and recovery is not a one-size-fits-all solution. We know that recovery is possible and ensuring people have access to the right treatment services when they need them is critical.**
- **BC is implementing a provincial approach to treatment and recovery services that will allow more people to access the care they need quicker and closer to home.**
- **As of January 2023, there are 3,260 publicly funded substance use beds.**
- **Since 2017, our government has added over 360 new adult and youth substance use beds (as of January 2023). We have made progress in the last year alone, including 106 new adult beds.**
- **Budget 2023 invests $586 million across the spectrum of services and supports for people struggling with substance use disorder with a focus on expansion of treatment and recovery beds, including 195 new treatment beds and a new model of seamless care.**

CURRENT SITUATION

According to December 2022 MHSU Bed Survey (Table 1):

- In total, there were 22,552 publicly funded MHSU beds/units of which 19,281 were mental health and 3,271 were substance use beds/units. This represents an increase of about 3.5% and 0.6% since December 2021[1] the survey for MHSU beds/units, respectively.
- Of all MHSU beds/units about 90.5% (or 20,405 beds/units) were designated for community services, while about 9.5% (or 2,147 beds/units) were designated for services in acute and tertiary facilities.

[1] HSIAR Division, Ministry of Health (2021). Dec 31, 2021. MHSU Bed Survey. RMS 1195 MHSU Bed Information 2021-12-31.xlsx

Table 1: Number of Publicly Funded MHSU Beds/Units in B.C.[2]

	IHA	FHA	VCHA	VIHA	NHA	PHSA	B.C. Total
Mental Health							
Community	1,879	4,358	7,581	2,807	520	138	17,283
Acute	137	266	229	174	54	-	860
Tertiary	164	269	216	178	69	242	1,138
MH Total	**2,180**	**4,893**	**8,026**	**3,159**	**643**	**380**	**19,281**
Substance Use							
Community	278	473	1,536	578	118	139	3,122
Acute				4*			4*
Tertiary			10**			135	145**
SU Total	**278**	**473**	**1,546**	**582**	**118**	**274**	**3,271**
Total Beds/Units							
Community	2,157	4,831	9,117	3,385	638	277	20,405
Acute	137	266	229	178	54	-	864
Tertiary	164	269	226	178	69	377	1,283
Total	**2,458**	**5,366**	**9,572**	**3,741**	**761**	**654**	**22,552**

- Community beds/units also include beds that are provided through the BC Housing Health Services Program. Through a partnership with BC Housing and health authorities, the Program provides increased access to safe and affordable housing units, directly managed, or funded through BC Housing, for individuals with MHSU conditions. Health authorities also provide a significant number of MHSU supported housing units for people with MHSU disorders.
- Additionally, there were 204 secure rooms, 18 observation units and 23 quiet rooms available for MHSU patients per the survey, December 2022 (Table 2). Secure rooms, operated by designated mental health facilities, offer seclusion to MSHU patients. Observation units, also operated by designated mental health facilities, accept involuntary patients for short periods of assessment, stabilization, and treatment before final treatment at a designated facility. Quiet rooms provide a non-stimulating environment to clients with complex behaviour not requiring a secure room.

Table 2: Number of Publicly Funded Secure/Observation and Quiet Rooms/Units in BC[2]

	IHA	FHA	VCH	VIHA	NHA	PHSA	B.C. Total
Secure Rooms	33	45	48	31	10	37	**204**
Observation Rooms	3			3	12		**18**
Quiet Rooms	3		8	8	3	1	**23**
Total	**39**	**45**	**56**	**42**	**25**	**38**	**245**

- While children and youth (ages 0-30) represent one third of the BC population[3] about 312[4] MHSU beds/units (or 1.4% of the total MHSU beds/units) are allocated to that demography (Table 3).
- The bed numbers in Table 3 exclude bed-based treatment services provided by the Ministry of Children and Family Development, such as youth forensic services, and bed-based treatment services offered by the Maples adolescent treatment centre[5].

[2] HSIAR Division, Ministry of Health (2022). Dec 31, 2022. MHSU Bed Survey. RMS 3874 MHSU Bed Information 2022-12-31.xlsx
[3] HSIAR Division, Ministry of Health (2023). Client Roster. Population data is extracted on March 10, 2023.
[4] Beds reported for clients under 31 years of age. Additionally, 32 beds were reported as Adult Supportive Bed Based Services (Supportive Recovery) by FHA for clients aged 19-24.
[5] Maples adolescent treatment centre provides beds to young people with psychiatric and behavioural disorders, and alcohol and drug residential treatment services for youth involved with the criminal justice system.

Table 3: Number of Publicly Funded Child and Youth Beds[2,4]

	IHA	FHA	VCHA	VIHA	NHA	PHSA	B.C. Total
Community	29	73	24	30	8	44	208
Acute	2	20		18	6		46
Tertiary	8		10			40	58
Total	**39**	**93**	**34**	**48**	**14**	**84**	**312**

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Beds are a treatment option that represent a small portion of a broad continuum of care for children and youth, and they are connected to a variety of treatment supports to help people achieve the best possible health outcomes.
- There are other MHSU beds that receive funding from the provincial government. For example, there are beds subsidized by the Ministry of Social Development and Poverty Reduction, and beds funded through special grants.

LAST UPDATED

The content of this fact sheet is current as of March 24, 2023, as confirmed by Christine Voggenreiter.

APPROVALS

2023 03-17 – Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03-24 – Christine Voggenreiter, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Non-Standard Characters and Diacritical Markers

Topic:

- In 2015, the Truth and Reconciliation Commission of Canada (TRC) published 94 Calls to Action to facilitate reconciliation among former students, their families, their communities, and all Canadians. Call to Action 17 reads as follows:

  We call upon all levels of government to enable residential school Survivors and their families to reclaim names changed by the residential school system by waiving administrative costs for a period of five years for the name-change process and the revision of official identity documents, such as birth certificates, passports, driver's licenses, health cards, status cards, and social insurance numbers.
- Call to Action 17 has directly impacted the business processes of the Vital Statistics Agency (Agency) through the request of Indigenous clients to use Indigenous language symbols and characters to reclaim their traditional names and use their Indigenous language names for the birth registration process.
- The Agency has been unable to fully apply the requested naming standards, involving the use of diacritical markers and mononyms, due to:
  - The *Name Act* prohibits single names; and
  - because the birth certificate is foundational identity, it would impact provincial and federal business partners whose electronic systems are not currently able to recognize Indigenous language characters. This may lead to Indigenous people unable to access some Government services.

Key Messaging and Recommended Response:

- **Government is committed to ensuring Indigenous peoples can register births and reclaim their names using traditional naming practices and Indigenous language characters.**
- **The Ministry of Citizens' Services (CITZ) has established a cross-government working group to focus on the activities required to update government systems and services and to work with Indigenous leadership to ensure the approach meets their needs and does not negatively impact Indigenous Peoples access to other services.**
- **CITZ has established an inclusive font for government websites that works with Indigenous languages to be used across a number of government websites, however the font has not been fully implemented yet.**
- **Government systems are interconnected and connected to federal government systems, so while we must proceed with these changes urgently, we must be thoughtful to ensure we don't disrupt people's access to critical services.**
- **While this change is significant and slow, it's critical we recognize its importance and relevance to the day to day lives of Indigenous peoples.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- The Agency has processed approximately 16 reclamations of Indigenous names without the use of Indigenous language characters. The Agency has had approximately 5 requests by new parents to register their child's birth using Indigenous language characters but has been unable to meet those requests.
- The Agency's current naming standards recognize only letters in the Latin alphabet (A through Z, no numbers), the set of French characters (Acute, Grave, Circumflex, Umlaut and Cedilla) and the use of apostrophes, periods, and hyphens if they are not next to each other or lead to confusion in interpretation.
- To enable Indigenous peoples to register their names in their languages using their full character sets, a Request for Legislation (RFL) was developed to be heard in the spring 2022 legislative session which would have included in the Names Act of mononyms, polynyms, and diacritical markers used in Indigenous names.
- As of January 26, 2022, this RFL is on hold. A joint working group led CITZ is responsible for coordinating a cross-government approach to enable use of Indigenous languages in communication, signage, services and official records, as described in the Declaration on the Rights of Indigenous Peoples Act Action Plan 2022-2027. The Agency is participating in this effort and intends to coordinate any future RFL with this group.
- As the birth certificate is a foundation identity document, any characters used in the structure of that identity must be able to be accepted by the systems of all business partners. Initial consultations with these business partners indicate extensive modifications across multiple systems is required. Other options may go part way towards a solution but would depend on the preferences and feedback of the affected Indigenous groups.
- The Agency would likely be able to modify its registration systems to allow for diacritical markers and mononyms in approximately 6 months after enabling legislative changes to the *Name Act*.
- The current impact to an individual who registers a name with Indigenous language characters that are unable to be recognized would be as follows:
    - At birth, the parent(s) could not apply for the child tax credit from Canada Revenue Agency or the Social Insurance Number from Service Canada.
    - BC would not be able to issue a service card for health care.
    - School systems would not be able to record the child's name for enrollment purposes.
    - ICBC would not be able to accept the name for a BCID, driver's license, or insurance purposes.
    - Employers would not be able to record employee legal names for tax purposes.
    - Private systems in the financial and legal sectors may not be able to record characters thereby limiting ability on many daily functions.
- Issuing a birth certificate that cannot be used in any other government systems will likely be viewed as demeaning and insincere to the spirit of the *United Nations Declaration on the Rights of Indigenous Peoples Act* (UNDRIP).
- The Ministry of Health and The Agency are represented on that working group.
- The scale of this task is significant and will likely take years to complete.

FINANCIAL IMPLICATIONS

Minor impact for the Agency but considerable across Government.

KEY BACKGROUND

- Individuals wishing to reclaim their traditional Indigenous names or register the birth of their child using Indigenous languages that include non-Latin characters cannot currently do so.
- The Agency is unable to use Indigenous language characters at this time due to the impact it would have on provincial and Federal business partners whose electronic systems are not currently able to recognize Indigenous language characters.
- The Agency is working with CITZ as the lead Ministry in government to address this issue.

LEGISLATIVE SESSION – ESTIMATES NOTE

Suggested Messaging:

- Government is committed to ensuring Indigenous peoples can register births and reclaim their names using traditional naming practices and Indigenous language characters.
- CITZ has established a cross-government working group to focus on the activities required to update government systems and services and to work with Indigenous leadership to ensure the approach meets their needs and does not negatively impact Indigenous Peoples access to other services.
- The scale of this change is significant and will take many years to complete.

LAST UPDATED

The content of this fact sheet is current as of February 5, 2023, as confirmed by Jack Shewchuk, Registrar General, Vital Statistics Agency.

APPROVALS

2023 02 06 – Jack Shewchuk, Vital Statistics Agency, Health Sector Information, Analysis & Reporting Division
2023 02 14 – Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Nursing Supply Numbers

Topic: Overview of the nursing workforce in BC, which includes Registered Nurses (RNs)/Registered Psychiatric Nurses (RPNs) and Licensed Practical Nurses (LPNs). Time trend data and national comparisons, where available, are provided.

Key Messaging and Recommended Response:

- **Nurses play an essential role in our health care system and the province is dedicated to actions that grow, retain, and support nurses.**
- **We know that the last several years have been incredibly challenging for all health care workers, and particularly nurses.**
- **It's why we launched a Health Human Resources (HHR) strategy that addresses many of the issues that affect nurses and we are investing in quality health care for people in BC.**
- **That is why government has continued to make investments to:**
    - **Expand nursing seats across the province – to date we've funded an expansion of 602 seats at public post-secondary institutions across BC.**
    - **Create easier pathways and financial supports for internationally trained nurses (IENs) and nurses returning to practice to get assessed. This includes covering the $3,700 application and assessment fees for IENs and up to $10,000 in bursaries for any additional education required for IENs or nurses returning to practice.**
    - **Hire and train 320 relational security officers to ensure workplace safety for nurses and health care workers across the province.**
- **Despite the challenges that we've been facing, it's important to note that between 2018 and 2022, we saw a 10% increase in workforce for RNs and LPNs- this number doesn't even include the 152 Nurse Practitioners we've added since 2018.**
- **We absolutely acknowledge more needs to be done. We are working on tackling the issues head on and have a clear and comprehensive HHR strategy to make the health system work for both patient and providers.**

If asked about agency nurses

- **Agency nurses are contracted as a last resort for vacancies and difficult to fill positions.**
- **It is critical to put this in perspective. On average in 2021/22, agency nurse hours made up 1.4% of total nurse productive hours in BC.**
- **Across all health authorities, agency and travel nurses were used extensively to staff vaccination clinics, testing centres, and contract tracing centres during the COVID-19 pandemic.**
    - **By expanding the utilization of agency nurses, health authorities minimized impacts to existing services and teams.**
- **We know that the highest utilization of agency nurses is in Northern Health Authority, where agency nurse hours made up 8.2% of total nurse productive hours in 2021/22.**
    - **This is due to the difficult to fill vacancies in rural and remote communities, and we should always be prioritizing patient access to care.**
    - **Northern Health has responded to this increase in utilization of agency nurses by introducing the Travel Resource Program, Prototype Rural Retention Incentive, and additional strategies to address the high vacancy rates that currently rely on agency nurses.**
- **As we've already mentioned, Agency nurses are contracted as a last resort for vacancies and difficult to fill positions, and this government is taking direct actions through our HHR plan to prioritize the recruitment, training and retention of nurses.**

CURRENT SITUATION

Headcounts and Full-Time Equivalents (FTEs) in 2022 [1]

- There were 52,116 nurses in BC (34,960 FTEs).
- Among them, 40,852 were RNs/RPNs (27,810 FTEs) and 11,264 were LPNs (7,150 FTEs).
- On average RN/RPN worked 0.68 FTE and LPN worked 0.64 FTE.

Growth Trend[2]

- The annual growth in total number of RNs/RPNs for the last 5 years (2018 to 2022) ranged from -0.2% to 4.6%, with the highest growth in 2021.
- The annual growth in total number of LPNs for the last 5 years (2018 to 2022) ranged from -0.9% to 5.4%, with the highest growth in 2020.

[1] Nurses in BC – Key Workforce Stats, Strategic Priorities Recruitment and Reporting, Health Sector Workforce and Beneficiary Services Division, December 2022,
[2] Ibid. 1

Regular Full-Time, Regular Part-Time, and Casual Employees[3]

- Workforce data provided by Health Employers Association of BC on employees classified under the Nurse Bargaining Association Collective Agreement reveal the following trends for 2021:
  - Regular full-time nurses delivered 68% of overtime hours and 59% of productive hours[4].
  - Regular part-time nurses delivered 25% of overtime hours and 28% of productive hours.
  - Casual nurses delivered 7% of overtime and 12% of productive hours.
- The percentage of overtime hours delivered by regular part-time nurses increased from 20% in 2017 to 25% in 2021. The percentage of productive hours delivered by regular part-time nurses increased from 25% in 2017 to 28% in 2021.
- Total proportional utilization of casual nurses has decreased. The percentage of overtime hours delivered by casual nurses decreased from 9% in 2017 to 7% in 2021. The percentage of productive hours delivered by casual nurses decreased from 16% in 2017 to 12% in 2021.
  - This change is perhaps in part because of the rise in agency nursing utilization, agency opportunities, and the corresponding decline in casual pools.
- The data also reveals an apparent substantial overlap between casual, part-time, and even full-time employees, which indicates that individuals are working multiple jobs.

Agency Nursing Utilization[5]

- On average in 2021/22, agency nurse hours made up 1.4% of total nurse productive hours in BC, with the highest utilization in Northern Health Authority (where agency nurse hours made up 8.2% of total nurse productive hours in 2021/22).
- In the first quarter of 2022/23, agency nurse hours made up 1.7% of total nurse productive hours – a continuation of the general upwards trend. Agency nurse hours made up 9.3% of total nurse productive hours in Northern Health in the first quarter of 2022/23.

Characteristics of the BC Nursing Workforce in 2021[6]

- 44% of RNs and 48% of LPNs are under the age of 40.
- 91% of RNs and 90% of LPNs are female.
- 94% of RNs and 37% of LPNs work in urban areas.
- 14% of RNs were internationally educated, while almost all LPNs were Canadian educated.
- 91% of RNs and 94% of LPNs are in Direct Care.
- 64% of RNs work in hospitals, 18% in community settings, and 6.5% in nursing homes/long term care.
- 36% of LPNs work in hospitals, 14% in community settings, and 41% in nursing homes/long term care.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Education and Training[7]

- In an average year, BC post-secondary institutes expect to graduate approximately:
  - 1,500 RNs
  - 120 RPNs
  - 300 LPNs
- The BC College of Nurses and Midwives recognizes 13 Bachelor of Science in Nursing (BSN) degree granting programs (9 universities, 3 colleges, and BC Institute of Technology) and 7 recognized colleges that partner with a university BSN program.

[3] Ibid. 1
[4] Productive hours refer to hours of scheduled paid work excluding overtime, leave, vacation, sick time, etc.
[5] Ibid. 1
[6] CIHI Workforce Database https://www.cihi.ca/en/health-workforce
[7] Health Sector Priority Occupation Profiles and Workforce Data, Strategic Priorities Recruitment and Reporting, Health Sector Workforce and Beneficiary Services Division May 2022

- The BC College of Nurses and Midwives recognizes educational institutions in 34 communities throughout BC that offer a practical nursing program.
- As of March 2021, the Ministry of Advanced Education and Skills Training funded 597 FTE targeted seats. On February 20, 2022, the BC government added 180 annual LPN intakes.
- Expand Training:
    - As of April 2022, there are a total of 5,758 targeted student FTEs in RN programs, or 1,901 targeted student seats.
    - As of March 2021, there are a total of 368 targeted student FTEs in RPN Programs (Douglas College – 248; Kwantlen Polytechnic – 120) or 160 targeted student seats.

LAST UPDATED

The content of this fact sheet is current as of February 20, 2023, as confirmed by Eric Larson.

APPROVALS

2023 02 28 – Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 04 06 – Eric Larson, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Physician Supply Numbers

Topic: Overview of BC's current complement of physicians, recent trends and comparison with other Canadian jurisdictions.

Key Messaging and Recommended Response:

- **Compared to other provinces, BC has a good supply of physicians and growth in supply continues to outpace population growth. Over the last five fiscal years, the number of physicians grew by 12.6%, while the BC population grew by 5.8%.**
- **Alternatively, we are making record investments and regulatory changes to improve on these numbers.**
- **We are expanding UBC's medical education programs, adding up to 128 new seats to address the growing demand for physicians in BC**
    - **The expansion includes 40 new medical school seats and up to 88 new residency positions, distributed amongst all four regional undergraduate medical schools.**
    - **The overall increase of 14% in medical school intake will raise BC's total number of students from 288 to 328 per year, benefiting medical programs across the province.**
    - **A further increase in residency seats mirroring the expansion of the undergraduate medical education program will add another 48 postgraduate medical education positions (family medicine and specialties) by 2028/29.**
- **We are expanding the Practice Ready Assessment (PRA-BC) program, a pathway for internationally educated family doctors from 32 seats to 96 seats by March 2024.**
    - **The IMG-BC residency program has grown from six annual entry positions in 2003 to 58 today, including 52 in family medicine. Since 2006, 427 family physicians and 66 specialists have been placed in 91 BC communities.**

- **We have also signed a new Physician Master Agreement, ensuring BC continues to attract new physicians through offering the best compensation in Canada.**
    - **The new Physician Master Agreement (PMA) represents a significant milestone in enhancing healthcare access for all British Columbians.**
    - **The three-year agreement will effectively reduce barriers for doctors, enabling them to provide the highest quality care to the people of BC**
    - **This collaborative approach has garnered widespread support among physicians across the province, demonstrating the PMA's potential to attract and retain doctors to better serve our communities.**

CURRENT SITUATION

- Compared to other provinces, BC has a good supply of physicians and growth in supply continues to outpace population growth; over the last five fiscal years, the number of physicians grew by 12.6%, while the BC population grew by 5.8%.
- In 2021/22, the Ministry counted 14,558 physicians under all payment sources.[1] Physicians receive payments through fee-for-service, alternative payments, capitation, or a combination of modalities.
- The College of Physicians and Surgeons of BC reported 15,058 active registrants in 2021/22. This count differs from the Ministry's as there is a subset of practicing physicians in the province who are not compensated through the public health system.[2]
- The Canadian Institute for Health Information (CIHI) estimates that BC has 260 physicians per 100,000 population;
    - 136 Family Medicine physicians per 100,000 and
    - 123 Specialists per 100,000.
- BC's figures are higher than the Canadian rate of 246 per 100,000 and behind only Nova Scotia (276), Newfoundland & Labrador (265) and Quebec (261) [3].
- Between 2017 and 2021, BC's supply of physicians grew by 14.7%, more than double the growth of BC's population (5.8%) over the same period[4].
- BC is increasing self sufficiency in physician training, while remaining an attractive destination for physicians relocating from other jurisdictions.
- Since 2017, additional funding has supported over 60 new annual residency positions in priority areas that include Anesthesiology, Emergency, Family Medicine, Gastroenterology, Geriatrics, Internal Medicine, Palliative Care, Pediatrics, Psychiatry, Gynecology, and Surgical Oncology.
- As outlined in the Ministry's Provincial Health Human Resource (HHR) Strategy:
    - The University of BC (UBC) will expand its medical school intake by 40 and its residency by up to 88, adding 128 additional new annual seats and positions to train more doctors in BC.

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[1] Integrated Analytics - Primary Care, Acute Care and Workforce, Health Sector Information Analysis and Reporting Division, February 2023. Note that Ministry data is now collecting information on physicians paid out of health authority global operating budgets. These physicians are included in the current counts but have not been in earlier counts.

[2] Annual Report 2021/22, BC College of Physicians and Surgeons, https://www.cpsbc.ca/about-us/annual-report - Verified by HSIAR

[3] Canadian Institute for Health Information (CIHI). Supply, Migration and Distribution of Physicians in Canada, 2021: Data Tables. Retrieved February 2023 from: https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34 - Verified by HSIAR

[4] *Ibid* 1.

- The Ministry continues to support the Ministry of Post Secondary Education and Future Skills to establish a second medical school for BC. $1.5M was allocated to Simon Fraser University to support planning and development of a business case for it's Surrey Campus.
- BC's Practice Ready Assessment (PRA-BC) program for internationally educated family physicians will increase from 32 to 96 annual seats by March 2024.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Challenges

- Discussion of physician shortage is likely less related to the total number of physicians and more likely related to changes in physician working preferences and distribution.
- The aging of the physician workforce could be an issue in the future as many are poised to retire and are reducing workload in the years prior to retirement. In 2021 the average physician age in BC was 49 years.[5]

Training

- In 2021/22, almost $163M (up from ~$135M in 2017/18) was allocated to support residency training in BC. Funding residency training will continue to increase annually in 2022/23 and beyond.
- First-year entry-level medical residency positions increased from 134 (2003) to over 362 positions annually in 2022, including a Family Medicine increased intake from 54 (2003) to 174 positions.
- Between 2017 and 2022, additional funding was also allocated to support over 60 new annual residency positions that includes key priority specialist areas: Anesthesiology, Emergency, Gastroenterology, Geriatrics, Internal Medicine, Palliative Care, Pediatrics, Psychiatry, Gynecology, and Surgical Oncology
- As outlined in the Ministry's Provincial HHR Strategy, UBC will further expand its intake of combined residency and medical school training by a total of 128 new annual seats and positions.

Advice/Recommentations

- Residents selected into IMG-BC positions are required to complete a return of service (ROS) in a health authority-identified underserved community upon finishing their residency program.
  - 52 of the 58 entry-level IMG-BC positions are in family medicine; the other six intake positions are in priority specialties that include psychiatry, internal medicine, and pediatrics.
- An IMG-BC resident completing Family Medicine is required to complete a 2-year ROS; and a 3-year ROS if practicing in a Royal College specialty.
- As of January 4, 2023, 427 family physicians and 66 specialists were placed in 91 communities.
- Government remains committed to its significant investment into medical education - it is expected that BC will see increasing benefits of this investment as expanded cohorts of newly trained medical residents' transition into practice within BC's diverse communities across the province.

LAST UPDATED

The content of this fact sheet is current as of February 15, 2023, as confirmed by Eric Larson.

[5] *Ibid*, 3 – Verified per HSIAR

LEGISLATIVE SESSION – ESTIMATES NOTE

APPROVALS

2023 02 15 – Eric Larson, Health Sector Information Analysis & Reporting Division
2022 03 10 – Martin Wright, Health Sector Information Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Summary of Family Physician Supply in BC

Topic: Overview of family physicians (FPs) supply in BC, including programs to educate, recruit and retain FPs.

Key Messaging and Recommended Response:

- **Retaining, recruiting, and training more family doctors in BC is a top priority for our government.**
- **That is why we have significantly expanded pathways for international medical graduates to practice in BC, such as tripling the BC Practice Ready Program in November from 32 seats to 96 seats by March 2024.**
    - **This includes a commitment of an additional $1.15M in funding for up to 16 candidates with priority given to Primary Care Networks.**
    - **As of December 5, 2022, 188 IMGs have successfully completed the PRA-BC Program and have been placed in 57 Return of Service communities across BC.**
    - **As of January 4, 2023, 427 family physicians have been placed in 91 communities.**
- **We have made significant expansions in post-secondary medical education at UBC's School of Medicine, most recently through our record investment of $995 in BC's Health Human Resources Strategy announced in the fall of 2022,**

Advice/Recommentations

- **Not only are we recruiting and training more family doctors: we are changing their payment structures to retain existing ones and attract more to practice in BC by ratifying the best physician master agreement in Canada this year and introducing a new Longitudinal Family Practice Payment Model that moves away from fee-for-service.**
    - **As of April 17, 2023, 2,777 family physicians have signed on to the new model so far.**

- **With 160 net new family physicians, who are either new to BC or were not practicing family medicine.**

- **All of these steps represent a comprehensive approach to ensuring BC's supply of family physicians meets our needs today and looks forward to the needs of tomorrow.**

CURRENT SITUATION

- In the 2021/22 fiscal year, 7,083 FPs and emergency medicine FPs (50% of all physicians) received payment from the Ministry for providing patient care services.[1] This corresponds closely to the number of FPs registered through CPSBC during the same time period.[2]
- In most years, BC's complement of FPs grows faster than the population: Between 2017/18 and 2021/22, the number of FPs grew by 11.2%; BC's population grew by 5.8%.
- BC compares favourably with other Canadian provinces in per population supply of FPs: according to the Canadian Institute for Health Information (CIHI), in 2021, BC had 136 FPs per 100,000 population, behind only Nova Scotia, Yukon and New Brunswick and well above the Canadian rate of 124 per 100,000[3].
- That ratio continues to grow for BC: From 129 per 100,000 in 2017 to 136 per 100,000 in 2021[4].
- BC also continues to train and qualify more FPs to practice:
  - First-year medical residency positions have increased from 134 (2003) to over 362 positions annually, including an increased Family Medicine intake from 54 (2003) to 174 positions in 2022.
- As outlined in the Ministry's recently announced Provincial HHR Strategy:
  Advice/Recommentations
  - BC's Practice Ready Assessment (PRA-BC) program for internationally educated family physicians will also increase from 32 (current) to 96 annual seats by March 2024.
- Table 1 illustrates the distribution of FPs across payment models over the last five fiscal years for which there is complete data. FP remuneration is trending away from fee-for-service as the exclusive payment modality to other models, e.g., such as service contracts, salary, sessional or capitation.

Table 1. Family Physician Headcounts by Payment Modality[1]

Modality	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Fee-for-Service Only (FFS)	4,649	4,680	4,675	4,840	4,992
Mixed FFS/Other Payments	1,411	1,557	1,700	1,589	1,737
Other Payments Only	310	262	266	330	353
Total	**6,370**	**6,499**	**6,641**	**6,759**	**7,082**

[1] Health Sector Information Analysis and Reporting Division, Integrated Analytics: Hospital, Diagnostic and Workforce, April 2023.
[2] CPSBC, 2021/22 Annual Report. Retrieved on February 7, 2023, from https://www.cpsbc.ca/files/pdf/2020-21-Annual-Report.pdf .
[3] CIHI, Supply, Distribution and Migration of Canadian Physicians, 2019: Data Tables. Retrieved electronically on February 7, 2023, from: https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34.
[4] *Ibid 3.*

- Table 2 provides detail on the number of FPs working under various payment arrangements, as of March 31, 2023. FPs are counted in each payment model under which they worked but only once in the total. Note that FPs who adopted the LFP payment model are counted under fee-for-service.

Table 2. Family Physician Headcounts by Payment Modality, Detail, 2022/2023[1]

Modality	Family Physicians
Fee-for-Service	6,732
Alternative Payments Program	1,241
Group Contract	77
Northern Model (capitation)	12
New-to-practice Contracts	209
Population-Based Funding (capitation)	69
Primary Care Strategy Funded APP	364
Total	**7,169**

* As of 2022/2023 Q3

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Postgraduate Medical Education (PGME)

- Family medicine residency positions continue to be expanded:
  - Aligned with Ministry's key priorities and BC's workforce needs, UBC continues to maintain a strong focus on training generalists and family medicine physicians to help support increased access to primary care.

Advice/Recommentations

  - As new family medicine residents move through their residency training programs, BC will continue to realize the benefits of the Ministry's significant investment into PGME training.
- UBC's family medicine program is distributed at 20 regionally based training sites across the province to:
  - Expose and prepare residents for the challenges and benefits of practicing in rural, remote, and other underserved communities.
  - Enhance health care service capacity across the province; note that medical residents also provide direct patient care while they train.
  - Upon completion of PGME, encourages these newly licensed physicians to establish a practice within the communities where they have been educated and trained.
- Residents selected into IMG-BC family medicine positions are required to complete a two-year return of service (ROS), in a health authority-identified underserved community upon finishing their residency program.
  - There are 52 of the 58 entry-level IMG-BC positions are in family medicine; the other six intake positions are in priority specialties that include psychiatry, internal medicine and pediatrics.
  - ROS placements in rural, remote, and other underserved communities support equitable access to patient care across BC.
  - As of January 4, 2023, 427 family physicians and 66 specialists have been placed in 91 communities[5].

Practice Ready Assessment BC Program

- The Practice Ready Assessment BC (PRA-BC) program offers a pathway to licensure in BC for internationally educated FPs who have completed residencies outside of Canada (see Practice Ready Assessment for Family Physicians Fact Sheet for more detail).

[5] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health. IMG-BC Community Placements. Data as of January 4, 2023.

- The program's curriculum includes a two-week centralized orientation in Vancouver and participation in a 12-week Clinical Field Assessment under the supervision of a fully licensed FP in a BC community.
- PRA-BC is funded by both the Ministry and the Joint Standing Committee on Rural Issues (JSC) - a joint partnership between the Ministry and Doctors of BC.
- PRA-BC supports improved access to FPs by requiring successful applicants to provide a three-year ROS in a health authority-identified community of need.
- The JSC has committed funding for up to 16 candidates per year for rural ROS placements.
- The Ministry has committed an additional $1.15M in funding for up to 16 candidates with priority given to Primary Care Networks.
- As of December 5, 2022, 188 IMGs have successfully completed the PRA-BC Program and have been placed in 57 ROS communities across BC.[6]

LAST UPDATED

The content of this fact sheet is current as of February 15, 2023, as confirmed by Eric Larson.

APPROVALS

2023 04 17 – Eric Larson, Health Sector Information, Analysis, and Reporting Division
2023 04 18 – Martin Wright, Health Sector Information, Analysis, and Reporting Division

[6] Physician Services; Health Sector Workforce and Beneficiary Services Division. PRA-BC PM Report 221205. Data as of December 5, 2022.

LEGISLATIVE SESSION – ESTIMATES NOTE

Virtual Care – Physician Payment Growth

Topic: Virtual care is a growing field that uses various telecommunication technologies to deliver health care services to patients at a distance. This fact sheet discusses virtual care provided by physicians' paid by the fee-for-service model.

Key Messaging and Recommended Response:

- **The use of virtual care increased significantly in response to the COVID-19 pandemic.**
- **In 2020/21, Virtual Care visits rose by 691.8%**
- **Virtual care continues to play an important role. However, recent data indicate a decrease in virtual care services relative to the same period in 2021/22. In the first three quarters of 2022/23**.
- **Virtual care is an important part of our health-care system; It was critical to ensuring people received the care they needed at the height of the Pandemic.**
- **We also realize virtual care may lack some attributes of in-person visits to a care provider.**
- **The new Physician Master Agreement includes a process for the creation of an independent Virtual Care Clinical Reference Group, that will provide the parties detailed guidance on clinical practice and the appropriate provision of virtual care together with in-person care.**
- **The Ministry of Health continues to work with our partners to explore best practices and policies on the appropriate use of virtual care that best supports patient needs, practitioner considerations, resources, and financial accountability.**

CURRENT SITUATION

- Virtual care has played a critical role in facilitating access to care during the COVID-19 pandemic. However, in 2021/22, utilization and expenditures of virtual care have decreased compared to 2020/2021[1]:
  - Total virtual care expenditures in 2021/22 were $802.7M, a decrease of 10.4% ($94.0M) from 2020/2021 ($896.7M).
  - Total virtual care services in 2021/22 were over 17 million, a decrease of 7.7% from 2020/21.
  - Among all virtual care fee codes in 2021/22, 20.6% (or $165.6M) of the total expenditure was for "TeleHealth GP Visit: Age 2-49", which was a temporary fee introduced due to COVID-19. The next highest expenditures were attributed to fee code "TeleHealth GP Visit: Age 60-69", with 10.2% ($81.5M) of the total expenditure, an increase of 5.9% from 2020/21.

[1] Ministry of Health Data are for fiscal years 2017/2018 to 2021/2022 inclusive, with the paid date as of the following September 30th for each fiscal year.

- Virtual care continues to play an important role. However, recent data indicate a decrease in virtual care services relative to the same period in 2021/22. In the first three quarters of 2022/23[2]:
  - Virtual care fee item visits and consultations, as a proportion of all visits and consultations, decreased from 54.7% to 47.4%.
  - Expenditure of virtual care visits and consultations decreased to $459.1M from $562.3M.
  - Virtual care visits and consultation services decreased from 11.3 million to 9.3 million.
  - Total in-person visits and consultations increased by 11.1%; services of FP in-person visits and consultations increased from 9.3 million to 10.4 million.
  - Among family practitioner (FP) virtual care services:
    - MSP services decreased by 17.3%, from 9.4 million to 7.8 million.
    - The number of patients decreased 8.0%, from 2.9 million to 2.7 million.
    - The number of participating physicians grew by 0.7%, from 5,804 to 5,845.

Virtual Care Fee Items Expenditures and Services Totals by Fiscal Year for Five Fiscal Years[3] [4] [5]

Fee Type	FISCAL YEAR									
	2017/2018		2018/2019		2019/2020		2020/2021		2021/2022	
	Expend-iture ($M)	Services	Expend-iture ($M)	Services	Expend-iture ($M)	Services	Expend-iture ($M)	Services	Expend-iture ($M)	Services
MSC Fee Items	$7.3	122,130	$10.3	163,692	$46.8	916,098	$896.7	18,529,437	$802.7	17,104,639
GPSC Fee Items	$13.0	708,939	$16.7	862,036	$18.2	948,928	N/A	N/A	N/A	N/A
SSC Fee Items	$15.4	387857	$16.4	423,288	$18.2	475,028	N/A	N/A	N/A	N/A
Total GPSC/SSC	**$28.4**	**1,096,797**	**$33.0**	**1,285,324**	**$36.4**	**1,423,956**	**N/A**	**N/A**	**N/A**	**N/A**
Total Virtual Care	**$35.8**	**1,218,927**	**$43.3**	**1,449,016**	**$83.3**	**2,340,054**	**$896.7**	**18,529,437**	**$802.7**	**17,104,639**
Percent Year-Over-Year Increase			21.1%	18.9%	92.2%	61.5%	971.9%	691.8%	-10.4%	-7.7%

FINANCIAL IMPLICATIONS

Total virtual care expenditures in 2021/22 were $802.7M.

KEY BACKGROUND

- "Telehealth Service" is a specifically defined term in the Medical Services Commission (MSC) Payment Schedule: "a medical practitioner delivered health service provided to a patient via live image transmission of those images to a receiving medical practitioner at another approved site, using video technology."
- In response to the pandemic, the General Preamble has been changed temporarily to include telephone calls in the definition of telehealth and where there is no telehealth fee for consultations, office visits, and non-procedural interventions, to allow a virtual care service to be claimed under the face-to-face fee, with a claim note record that the service was provided via telehealth.
- Initially, the delivery of telehealth services payable under the MSC Payment Schedule was restricted to a health authority facility. To support physicians and patients that were not physically close to a health authority facility, that requirement was removed in 2011.
- Since then, the Ministry has seen significant increases in utilization across all specialties, but particularly in Family Physician telehealth fees.
- Prior to the pandemic, most physician virtual care visits were delivered through use of private, internet-based providers.

[2] Ministry of Health System Information, Analysis and Reporting Division Integrated Analytics: Primary & Acute Care and Workforce Branch, Medical Services Plan Database, updated February 6, 2023.
[3] Ministry of Health Data are for fiscal years 2017/2018 to 2021/2022 inclusive, with paid date as of the following September 30th for each fiscal year.
[4] Data are for medical, nurse practitioner and midwives claims only.
[5] Fees originally established by GPSC and SSC were transferred to the general MSC Payment Schedule effective April 1, 2020.

- Currently there are 257 Virtual Care fees[6] for medical specialties in the MSC Payment Schedule[7] These include Telehealth (206 fees) and services using other platforms (i.e., telephone, e-mail, text, fax).
- 10 fees originally established under the General Practice Services Committee (GPSC) and 8[8] fees originally established under the Specialist Services Committee (SSC) transferred to the MSC Payment Schedule April 1, 2020, per the Physician Master Agreement.
- 25 new Virtual Care fees have been temporarily approved to support access to healthcare during the pandemic and 6 virtual care fees temporarily deleted to accommodate the changes.
- See the Temporary Changes to the MSC Payment Schedule and Fee-for-Service Physician Payments factsheet for a full summary of changes.

LAST UPDATED

The content of this fact sheet is current as of February 14, 2023, as confirmed by Eric Larson.

APPROVALS

2023 02 15 - Eric Larson, Health Sector Information Analysis & Reporting
2023 02 28 - Martin Wright, Health Sector Information Analysis & Reporting Division
2023 03 06 - Rob Byers, Finance and Corporate Services Division
2022 03 20 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[6] Include temporary fees to support access to healthcare during COVID-19 pandemic.
[7] Ministry of Health. Healthideas fee item database
[8] Ministry of Health. Healthideas fee item database.

LEGISLATIVE SESSION – ESTIMATES NOTE

Access to Practical Nursing Bursary

Topic: The Ministry of Health has implemented a bursary to incentivize Health Care Assistants (HCAs) to train to become Licensed Practical Nurses (LPNs) by covering the costs of tuition and fees for publicly funded Access to Practical Nursing (APN) programs in BC.

Key Messaging and Recommended Response:

- **As outlined in our HHR plan, this government is dedicated to actions that recruit, retain, and support all healthcare workers.**
- **In August 2022 we announced $3 million in funding to provide financial support to Health Care Assistants (HCAs) who want to advance their careers and develop skills to become licensed practical nurses (LPNs).**
- **The Ministry of Health developed this Access to Practical Nursing (APN) Education Incentive Bursary to help address the increasing demand for LPNs in BC.**
    - **Eligible HCAs receive $10,000 to cover the cost of the APN program and participants are required to sign a 12 or 24-month return-of-service agreement, committing to work in the health-care system following graduation from the program.**
- **Expanding support for HCAs to upskill and expand their careers is one of the many ways that the Province is addressing pressures in staffing on BC's health system.**
- **This program has increased the number of health-care staff available to support the people in BC. As of February 2, 2023, 68 APN students or recent graduates are benefitting from this bursary.**

CURRENT SITUATION

- On August 23, 2022, the Ministry publicly announced $3 million in funding to enable Health Care Assistants (HCAs) to apply their skills and experience and accelerate their training to become a Licensed Practical Nurse (LPN).
- HCAs enrolled in an APN program at a recognized publicly funded post-secondary institution (PSI) in BC, may be eligible to receive a $10,000 bursary.
- The new Access to Practical Nursing education incentive bursary will help to offset APN program tuition and fee costs at publicly funded post-secondary institutions (PSI) across BC for up to 300 learners.
- As of February 2, 2023, 68 APN students or recent graduates are benefitting from this bursary[1].
- Administration of the bursary began in the fall of 2022 by Choose to Care, a division of the Health Employers Association of BC (HEABC).

[1] HealthMatch BC: APN Education Incentive Bursary Cumulative Data August 23, 2022 - February 2, 2023

- Limiting eligibility to publicly funded PSIs allowed the Ministry to achieve the right geographic mix and generate a steady supply of new LPNs more consistently around the province, using the tool of program size, timing and distribution we have established with the public PSIs. Striking this balance is critical to equitably addressing nurse shortages, especially in rural and remote communities in BC. This additionally solidifies the government investment in new APN programs.
- Eligible bursary applicants include new students registered in an APN program between September 1, 2022, and May 31, 2024, and recent graduates or mid-stream students who began the APN program no sooner than September 1, 2021.
- APN bursary applicants must:
  - Commit to a 12 or 24 month return of service (ROS), dependent on the participant's full-time equivalent (FTE), working as an LPN in BC's public health system[2] upon graduation.
    - Agree to complete up to three surveys that will be used to enhance student/new graduate outcomes and streamline bursary processes.
    - Be registered with the BC Care Aid & Community Health Worker Registry (APN student applicants only).
    - Be registered with the BC College of Nurses and Midwives (BCCNM) (new graduate applicants only).
    - Submit Proof of APN program registration at one of the following public post-secondary institutions in BC:
      - Coast Mountain College
      - Nicola Valley Institute of Technology
      - Northern Lights College*
      - Vancouver Community College
      - Vancouver Island College*
      - Okanagan College*
      - North Island College

    * *Pending BCCNM program recognition*
    - Submit transcripts and proof of tuition fee payment each semester.
- The bursary will be paid in equal installments on a semester basis to a total of $10,000.
  - Mid-stream APN students and new graduates eligible for the bursary will be reimbursed for semester work completed at the time of application.

FINANCIAL IMPLICATIONS

Up to 294 students enrolled in an APN program at recognized post-secondary institutions between September 2021 and May 2024, are eligible to receive this $10,000 bursary for a total government investment of $2.94M.

KEY BACKGROUND

- Nurses are in short supply and in high demand across the health system and all service delivery areas. This includes LPNs, who play an integral role as members of the health care team. To meet the increasing demand for LPNs in BC, the Ministry of Health has developed the Access to Practical Nursing Education Incentive Bursary.
- APN programs are a unique career laddering program for HCAs wishing to train as LPNs. APN programs allow students to apply training and experience garnered as an HCA to accelerate their training as an LPN. Incentivizing HCAs to enroll in this program through financial support will help retain HCAs and expedite the number of LPNs available to support more immediate LPN staffing needs.
- BC's Health Human Resources Strategy, a key commitment in the Minister of Health's mandate letter highlights the importance of provincial post-secondary education and training as a primary source of

[2] Health Authority owned and operated, affiliate or private long-term care (LTC), assisted living (AL) setting, or any Health Authority owned and operated home support/community setting within BC, excluding contract agencies supplying temporary and/or short-term staffing solutions to eligible facilities.

healthcare workers in BC Tuition support to become a licensed practical nurse is a key area of focus in the Strategy to remove barriers to education and address the increased demand for nurses in BC.[3]

LAST UPDATED

The content of this fact sheet is current as of February 17, 2023, as confirmed by Miranda Mason, Executive Director, Health Workforce Planning and Implementation Branch.

APPROVALS

2023 02 24 - Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 06 - Rob Byers, Finance and Corporate Services Division

[3] BC Ministry of Health. September 2022. BC's Health Human Resources Strategy. Pg. 39. Retrieved from: https://news.gov.bc.ca/files/BCHealthHumanResourcesStrategy-Sept2022.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

Agency Nurses

Topic: Health Authority (HA) usage of temporary agency services to address health system nursing workforce demands.

Key Messaging and Recommended Response:

- **Agency nurses are contracted as a last resort for vacancies and difficult to fill positions.**
    - **It is critical to put this in perspective. On average in 2021/22, agency nurse hours made up 1.4% of total nurse productive hours in BC.**
- **While Agency nurse costs in BC increased from $8.7 million in FY 2018/19 to $64 million in FY 2021/22 it is critical to note that:**
    - **Across all health authorities, agency and travel nurses were used extensively to staff vaccination clinics, testing centres and contact tracing centres during the COVID-19 pandemic.**
    - **By expanding utilization of agency nurses, health authorities minimized impacts to existing services and teams.**
- **We know that the highest utilization of agency nurses is in Northern Health Authority, where agency nurse hours made up 8.2% of total nurse productive hours in 2021/22.**
    - **This is due to the difficult to fill vacancies in rural and remote communities, and we should always be prioritizing patient access to care.**
    - **Northern Health has responded to this increase in utilization of agency nurses by introducing the Travel Resource Program, Prototype Rural Retention Incentive, and additional strategies to address the high vacancy rates that currently rely on agency nurses.**
- **In addition, Government invested $1.1 million to launch the first nursing degree program in the North East delivered by UNBC in Fort St John, in partnership with Northern Lights College and Northern Health.**
    - **The first cohort started in Fall 2022 with 12 of 16 seats filled (in subsequent years full capacity is anticipated to be 32 students**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

Health authorities utilize services of contracted agencies to address episodic and ongoing nursing vacancies in hospital, community, and long-term care (LTC) sectors as well as to ensure safe and quality care for people across BC Agency service utilization is especially significant in rural and remote communities in BC.
The Provincial Health Services Authority has created an inventory of all agencies and has standardized contracts to pay the same hourly rate.[1]

- Work is underway to reduce the reliance on agency staffing. Agency nurse utilization data is available; however, given that active bargaining is underway with the Nurses' Bargaining Association, this is confidential information that is not for public consumption.
- The Health Employers' Association of BC and BC Nurses' Union are currently negotiating for a renewed collective agreement. There is a shared interest in increasing the number of nursing hours in the system.
- A key action in *B.C.'s Provincial Health Human Resources Strategy* includes the development of a new provincial travel resource pool based on Northern Health's model to address short-term and urgent staffing needs across the province and help reduce the incidence of overtime and unfilled shifts – factors which have been key in driving up the utilization of agency nursing.[2]
- Action 34 in the Strategy states the Provincial Health Human Resources Coordination Centre will develop a new provincial travel resource pool based on Northern Health's model, which supports deployment of nursing resources in communities of need for short-term support.
- By aligning health authorities around a provincial Strategy, the Ministry of Health will enable deployment between regions and reduce competition.
- The provincial Strategy will build on outcomes and insights from Northern Health Authority's travel resource pool.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Through the Provincial Health Human Resources Coordination Centre (PHHRCC), the Ministry continues to work with health authorities and other health system partners to ensure that BC has the right supply, mix, and distribution of health care professionals to meet patient and population needs.
- Agency nurses are required to be registered with the BC College of Nurses and Midwives and practice in alignment with BCCNM's Bylaws and Standards of Practice and employer policies.
- The average duration of assignment is approximately two weeks; however, there are a number of assignments that have extended from two to four months in duration to cover long-term absences that Northern Health has been unable to fill with internal applicants.[3]
- Advice/Recommentations; Government Financial Information

- Agencies are responsible for setting pay rates for their staff. This may be higher than the standard scale[4] for hospitals or care facilities; however, publicly funded health authorities in BC offer comprehensive compensation packages for regular-status employees, which include significant employer-paid benefits and incentives.[5]

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[1] Ministry of Health. May 5, 2022. Agency Nurse Contracts Excel (Licensed Practical Nurse; $59.00; General Registered Nurse, $69.12). Personal email communications with Laura Heinze, Director, Planning, Integration and Partnerships, Health Workforce Planning and Strategic Initiatives
[2] Ministry of Health. Hancock, Lynn. October 2022. Agency Nursing – Research and Provincial Utilization Analysis
[3] Marc Lawrence, Executive Director, Travel Resource Program, Northern Health. Personal email communications. February 9, 2023.
[4] BC Nurses' Union. 2019-2022 Wage Grid Collective Agreement: General Wage Scale. Retrieved from: https://www.bcnu.org/Contracts-Bargaining/Documents/NBA_Wage_Grid.pdf, accessed February 8, 2023.
[5] HealthMatch BC. Salary, Employer-Paid Benefits, and Incentives for Nurses in BC Retrieved from: https://www.healthmatchbc.org/Nurses/Financial-Assistance-and-Benefits, accessed February 8, 2023.

- Agencies also charge an administration fee to the health employer in addition to the nurse's wage.

Northern Health Authority Response to Nursing Shortage

- Northern Health has developed a health human resource strategy with a multi-faceted approach to nursing workforce planning, recruitment, and retention in response to the recommendations in the 2018 Auditor General's report *An Independent Audit of the Recruitment and Retention of Rural and Remote Nurses in Northern B.C.* In support of the recommendation regarding distribution of nursing education programs in the north, Government invested $1.1 million to launch the first nursing degree program in the North East delivered by UNBC in Fort St John, in partnership with Northern Lights College and Northern Health.
    - The first cohort started in Fall 2022 with 12 of 16 seats filled (in subsequent years full capacity is anticipated to be 32 students). (See: *OAG Independent Audit of the Recruitment and Retention of Rural and Remote Nurses in Northern BC Fact Sheet*).
- Northern Health created a Travel Resource Program (NH-TRP) in 2018 and has been actively recruiting nurses who have an interest in working in rural and remote communities but may not be able to relocate permanently to those communities. The NH-TRP contributes directly to service stability in rural and remote regions of the health authority. Nurses are deployed through a triaging process to communities and facilities with the greatest predicted need. As of September 2022, Northern Health Authority reported that: [6]
    - 101 Registered Nurses, Registered Psychiatric Nurses, and Licensed Practical Nurses were employed by the TRP to provide support in acute care, community care, and long-term care settings.
    - 28% of TRP employees have home addresses outside of the province of BC and are therefore net-new to the provincial healthcare system.
    - In July 2022, the TRP provided approximately 7,500 hours of service to Northern Health sites with the majority of these hours provided in underserved communities in the Northeast and Northwest.

LAST UPDATED

The content of this fact sheet is current as of February 22, 2023, as confirmed by Melissa Murdock obo Zachary Matieschyn, Executive Director, Nursing Policy Secretariat.

APPROVALS

2023 02 22 – Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[6] Ministry of Health. Hancock, Lynn. October 2022. Agency Nursing – Research and Provincial Utilization Analysis.

LEGISLATIVE SESSION – ESTIMATES NOTE

Alternative Payment Plan for BC Cancer Physician Resources

Topic:

- The Alternative Payments Program (APP) funds health authorities and other agencies to engage physicians on a service contract, salary, or sessional basis in situations where fee-for-service payments are ineffective in attracting and maintaining adequate physician services.
- BC Cancer is primarily funded through the Alternative Payments Program service contract and salary arrangements due to patient complexity, scope of care and a multidisciplinary team approach. This is an overview of the current and incremental funding available to BC Cancer through APP.

Key Messaging and Recommended Response:

- **We are committed to ensuring patients in BC have timely access to cancer treatment. One of the key priorities of the Province's 10-year Cancer Action Plan and initial $440 million investment is to introduce revised pay structures to ensure BC is attractive and competitive for oncologists and cancer care professionals.**
- **BC Cancer currently has 256.56 funded physician FTEs, which is $98.2M in Alternative Payments Program (APP) funding, approved and available to spend on physician services. This includes 19.60 FTEs awarded and successfully implemented through the Physician Master Agreement mandated Workload Funding process to provide additional funding to address workload pressures.**
- **There are multiple types of oncologists and various contract rates. The new Physician Master Agreement includes opportunities for specialists, such as gynecological oncologists, to negotiate adjustments to contract rates and specialist fee items beyond the effective general increases for all physicians across the three-year term of the agreement.**
- **The BC Physician Master Agreement (PMA) is by far the best agreement for physicians in Canada this year. The new three-year tentative PMA will provide a total incremental cost increase of $708 million by the end of the third year.**

CURRENT SITUATION

- BC Cancer currently has 271.27 funded physician FTEs, of which is $104.3M[1] in APP funding, approved and available to spend on physician services.
- BC Cancer was awarded an additional 22.60 FTEs through the 2019 Physician Master Agreement Workload Funding process, of which 19.60 have been implemented to date. The remaining 3.00 FTEs have been awarded but are awaiting implementation due to recruitment delays and overarching contract negotiations.

Government Financial Information; Security Concern

- The 22.60 FTEs allocated to BC Cancer is 19% of the total 121.98 FTEs distributed through the 2019 Physician Master Agreement Workload Funding (2019/20 to 2021/22).
- In July 2021, BC Cancer was approved for an additional 25.0 FTEs funded through APP for their Advanced Recruitment Plan while the 10-year Provincial Cancer Plan is under review.
- Given the significant amount of time required to recruit an additional 25 FTE of oncology specialists to BC Cancer, the Advanced Recruitment Plan funding supported two temporary BC Cancer compensation initiatives in 2021/22 and 2022/23 to assist with retaining existing BC Cancer medical and radiation oncologists and compensating them to provide an exceptional volume of services to further reduce wait times with the existing complement of physicians. These are described below.
    - A retroactive one-time payment paid a lump-sum of up to $30,000 to eligible Medical and Radiation Oncologists. $6.2M in funding was provided by the Ministry and payment was made by BC Cancer to 232 eligible physicians in July 2022 and December 2022 to recognize extraordinary levels of service provision between July 2021 to May 2022.
    - Temporary prospective payments to full-time physicians in the Medical and Radiation Oncology programs within BC Cancer for additional consultations and follow up visits beyond what they are already providing. This initiative began June 1, 2022 and will be approved to continue until September 30, 2023 for eligible physicians.
- Use of the Advanced Recruitment Plan funding for the prospective initiative permitted Medical and Radiation Oncology Department physicians to work over 12,000 additional hours[2] across 6 BC Cancer sites in 22/23 to support a reduction in waitlists for consults and follow-up appointments.
- In 2023/34 ,the Ministry continues to enable additional workload above 1.0FTE to be taken on by the existing physician workforce, while recruitment is underway for fulfilling the remaining Advanced Recruitment Plan vacancies. Beginning May 1, 2023, through the Excess Workload initiative, additional payments above 1.0 FTE will allow eligible Salaried and Service Contracted physicians to work beyond their regularly scheduled hours and be paid for every incremental hour of service provided, up to 1.2FTE.
- The authorization to provide up to an additional 20% of paid hours by medical and radiation oncologists in 2023/24 will enable expanded service provision and support further reduction in waittimes for a broader scope of oncology services including weekend and evening chemotherapy clinics and inpatient services.
- While the above temporary initiatives were approved to help address immediate compensation concerns among existing BC Cancer physicians, HEABC also completed a jurisdictional scan to review the competitiveness of BC's compensation for oncologists compared with Canadian and some international jurisdictions.
- Based on the jurisdicational scan's findings, the Ministry will provide $7.5M in funding to BCCA to compensate eligible contracted and salaried medical, radiation and hematogology oncologists (estimated at 262.4 FTEs provincially once filled) an additional $28,000 annually per FTE[3]. This exceptional rate increase will be offered as of April 1, 2023 to eligible physicians in addition to the 2022 PMA contract compensation lifts [4] and will make BC's medical, radiation, and hematology oncologist workforce one of the highest compensated in Canada on both an hourly and annual income basis.
- In addition, the Ministry will provide increased funding to ensure all General Practitioner Oncologists (GPO) are paid at the maximum range for their APSA practice category.[5]
- The BC Cancer Advanced Recruitment Plan (25.0 FTE) combined with approved Workload Funding from 2019/20 to 2021/22 (22.6 FTE) totals 47.6 new APP funded FTE physician positions.

[2] Final utilization submission outstanding for 22/23; based on latest projectition from PHSA as of April 4, 2023.
[3] Salaried physicians will receive $25,000/FTE (89% of the service contractor rate to keep parity with the APSA grid).
[4] PMA income increases are partially negotiated by PMA-mandated committees, so the final rates will result from those discussions and cannot be pre-determined
[5] APSA Practice Category for GPOs is GP Defined Scope A (GPDSA) offering a maximum of $289,966 based on 21/22 rates and will be subject to PMA increases.

FINANCIAL IMPLICATIONS

- The current approved APP funding based on currently implemented physician resources is 271.27 FTEs at a value of $104.3M[6], including 19.6 FTEs of additional 2019 Workload Funding FTEs and 17.2FTE of approved Advanced Recruitment Plan funding that have been implemented to date.
- A remaining 10.8 FTEs of unimplemented APP funding is available to support additional service delivery upon recruitment and/or conclusion of contract negotiations. These 10.8 FTE of available APP funding is comprised of 7.8 FTEs of Advanced Recruitment Plan funding 3.0 FTEs of Workload Funding..
- The total APP budget available to BC Cancer is 282.1 FTEs, or $109.50M in total APP funding.[7]
- A Briefing note is in process to secure APP funding for the the $7.5M in Oncologist increases and additional GPO top-ups funding for April 1, 2023.

KEY BACKGROUND

- BC is launching a 10-year cancer action plan covering the full continuum of care that will transform service delivery to meet growing demand in the province.
- As patients are living longer and better, cancer care is changing due to personalized treatments. This new treatment method has had an impact on service delivery and, as a result, physicians resourcing demand has increased.
- For each fiscal year of the 2019/20 to 2021/22 Physician Master Agreement, Government has increased the budget for existing Service Contracts and Salary Agreements, in an amount equivalent to the growth rate in the Available Amount (Workload Funding) to support the addition of new Physician Services including the Cancer program.
- PHSA also reports approved funding for 103.82 FTEs from the health authority's operating budget. The FTEs are allocated across physician groups within Cancer Agency. This includes 11.65 FTEs approved in April 2021 to be allocated to Medical, Radiation and Gynecological Oncology physicians alongside the Ministry funded Advanced Recruitment Plan. Along with 33.6 physician FTEs recently approved across six centers as part of the BC Cancer $41M Global Operating allotment in 2022/23[8]. These FTEs have been partially implementedand the remaining FTEs are in the recruitment process.

LAST UPDATED

The content of this fact sheet is current as of April 21, 2023, as confirmed by Niya West, A/ Executive Director, Compensation Policy and Programs Branch.

APPROVALS

2023 04 21 - Marie-Josee Roy obo Rob Byers, Finance and Corporate Services Division
2023 04 22 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

Government Financial Information; Security Concern

LEGISLATIVE SESSION – ESTIMATES NOTE

Amalgamation of Health Profession Regulatory Colleges

Topic: Following recommendations of the Steering Committee on Modernization of Health Professional Regulation (the "Steering Committee", see Health Profession Modernization Fact Sheet), the Ministry is working in collaboration with health profession regulatory colleges to reduce the number of regulators in BC to six.

Key Messaging and Recommended Response:

- **Amalgamating the regulatory colleges from 15 to 6 is a Ministry of Health priority.**
- **Amalgamation was identified in the Cayton report, as well as the final recommendations report of the all-party Steering Committee on Mondernization o Health Professional Regulation, as a way to increase public protection and improv efficiency and effectiveness of regulation.**
- **Amalgamations are intended to ensure colleges have enough resources (through economies of scale) to properly regulate.**
- **Fewer regulatory colleges will directly support patients and families in BC:**
    - **- Reducing the colleges from 15 to 6 will make it easier for the public to determine who they should contact regarding concerns about the care received by a health professional.**
    - **- For example, as a result of the amalgamation of the three nursing regulator colleges, there is now a single point of contact for concerns about the professional practice or behavior of any nurse.**

CURRENT SITUATION

- As of February 2023, the number of health profession regulatory colleges in BC has been reduced from twenty (in 2020) to fifteen.
- On October 19, 2022, the Government announced it "will continue finalizing the amalgamation of colleges from 15 to six." [1] To achieve this, two further amalgamations are required; one amalgamation to form a college of allied health professionals (seven existing colleges) and one to form a college of complementary and alternative health care professionals (four existing colleges).
- As of February 2023, the Ministry and eleven regulators have been actively engaged in work to progress the two outstanding amalgamations, with a first phase of work focused on establishing a governance framework to guide the amalgamations.

FINANCIAL IMPLICATIONS

- Government has committed to providing financial support to assist the eleven colleges still being amalgamated, including hiring a resource to assist in the development of a governance/decision making framework.

[1] Patients the focus of new health legislation | BC Gov News

- Health profession amalgamations completed to date have been funded directly by the amalgamating colleges. Due to lacking resources within the eleven colleges still to be amalgamated (they are all small colleges), Government financial assistance will be required to assist with these outstanding amalgamations. The amount of this financial assistance is still to be determined.

KEY BACKGROUND

- On August 27, 2020, the Steering Committee on Modernization of Health Professional Regulation (the Steering Committee) released its final recommendations report: *Recommendations to modernize the provincial health profession regulatory framework (PDF, 669KB)*. Included within the report is a recommendation to reduce number of regulatory colleges in BC from 20 to six (currently this number has been reduced to 15 colleges) to increase public protection and improve efficiency and effectiveness of regulation.
- Since the report was released, three regulatory college amalgamations have already taken place, the amalgamation of the nursing and midwifery colleges to form the BC College of Nurses and Midwives (BCCNM) in September 2021, the amalgamation of the physicians/surgeons and podiatric surgeons colleges into the BC College of Physicians and Surgeons (CPSBC) in September 2021 and most recently the amalgamation of the four former oral health colleges (dentistry, dental hygiene, dental technology and denturism) to form the BC College of Oral Health Professionals (BCCOHP) in September 2022.
- As announced by Government on October 19, 2022, the remaining amalgamations are the formation of two multi-profession "umbrella" regulators:
  - A college of allied health and care professionals, comprised of dietitians, occupational therapists, opticians, optometrists, physical therapists, psychologists and speech and hearing professionals;
  - A college of complementary and alternative care professionals, comprised of chiropractors, massage therapists, naturopathic physicians and traditional Chinese medicine practitioners and acupuncturists.

LAST UPDATED

The content of this fact sheet is current as of February 17, 2023 as confirmed by Mark Mackinnon, ED, Professional Regulations and Oversight.

APPROVALS

2023 02 22 – Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Ambulance Paramedics and Ambulance Dispatchers Bargaining Association Collective Agreement

Topic: The Ambulance Paramedics and Ambulance Dispatchers Bargaining Association (APADBA) and the Health Employers' Association of BC (HEABC) 2022-2025 Collective Agreement.

Key Messaging and Recommended Response:

- **I am pleased that BC Emergency Health Services (BCEHS) and APBC have reached a three-year collective agreement for paramedics and emergency medical dispatchers in BC.**
- **This is great news for approximately 5,000 paramedics, emergency call-takers and medical dispatchers in our province who work tirelessly to make sure that they can provide immediate medical care to British Columbians.**
- **The three-year ratification, which goes from April 1, 2022 to March 31, 2025, includes:**
- **The ratified collective agreement includes a number of improvements:**
    - **General wage increases each year of the agreement.**
    - **A cost of living allowance in 2023 and 2024.**
    - **Increases in shift premiums:**
        - **E.g. Night shift premium increase to $2/hour and increased hours of coverage (6 p.m. – 6 a.m.)**
        - **E.g. Weekend shift premium increased to $2.25/hour for all hours between 6 p.m. Friday and 6 a.m. Monday.**
    - **Phasing out of the scheduled on-call shift pattern.**
    - **Increased DEI provisions, including work to advance Indigenous specific anti-racism efforts.**
    - **Improved benefits coverage for mental health and other items.**
- **This ratification will support several initiatives that the ministry is focused on, including improving on-call coverage and response times in rural and remote communities.**

- **The changes will be implemented over the coming months, and I extend my gratitude to everyone at BCEHS for their hard work and dedication in the service of patients throughout BC.**

CURRENT SITUATION

On February 15, 2023, employees covered by APADBA voted in favour of ratifying a three-year agreement between APADBA and HEABC for the period April 1, 2022-March 31, 2025. This agreement was negotiated under the Government's 2022 Shared Recovery Mandate.

FINANCIAL IMPLICATIONS

The 2022-2025 APADBA collective agreement represents approximately $427.2 million in annual expenditure on compensation plus the wage increases negotiated under the Shared Recovery Mandate (see below).[1]

KEY BACKGROUND

- The 2022-2025 APADBA Collective Agreement covers 4,947 employees or 3,370 Full Time Equivalents (FTEs).[2]
- Primary Care Paramedics make up about 71% of active employees.[3]
- APADBA consists of one union, the Canadian Union of Public Employees (CUPE) Local 873, which represents employees in the ambulance subsector.
- Paramedics and ambulance dispatchers work for BC Emergency Health Services (BCEHS), which is part of the Provincial Health Services Authority.
- A standalone bargaining association, the Ambulance Paramedics and Ambulance Dispatchers Bargaining Association, was established on January 18, 2018. Administrative and support staff at BCEHS who are represented by BC Government and Service Employees Union remain in the FBA.

2022 Bargaining Round (Shared Recovery Mandate)

Highlights of the 2022-2025 collective agreement between APADBA and HEABC are as follows:

- General wage increases (GWI):
  - Year 1 – a flat increase of $0.25 per hour, which provides a greater percentage increase for lower-paid employees, plus a wage increase of 3.24%;
  - Year 2 – 5.5% plus a potential cost-of-living adjustment to a maximum of 6.75%;
  - Year 3 – 2% plus a potential cost-of-living adjustment to a maximum of 3%.
- Targeted Universal Hourly Rate increases for specific classifications, from $0.75 to $1.25 an hour (after the above GWIs are applied).
- Shift Premiums:
  - Night shifts (18h00 to 06h00): $2.00/hour;
  - Weekends (18h00 Friday to 06h00 Monday): $2.25/hour;
  - The above premiums will apply to employees working callout shifts;
  - Alpha Paramedic Shift between 18h00 and 06h00: $3.60/hour;
  - Where applicable, employees will be entitled to multiple premiums concurrently.
- On-call wage increase to $12.00 from $2.00.
- Recruitment and Retention Initiatives:
  - An expedited job-posting process for Regular and Irregular Primary Care Paramedic positions;
  - Five days on paid sick leave for on-call employees per calendar year;

[1] PSEC Public Sector Compensation Annual Forecast 2022 (unreleased) pg. 34.
[2] PSEC Public Sector Compensation Annual Forecast 2022 (unreleased) pg. 34.
[3] HEABC Fact Sheet Ambulance Subsector, retrieved October 1, 2019 from: http://www.heabc.bc.ca/public/Bargaining/2019/FactSheets/FactSheetAPAD-2018.pdf

  - A Frontline Supervision Working Group jointly established by CUPE 873, BCEHS, and HEABC;
  - A provision allowing for voluntary job sharing of single full-time positions by two regular full-time employees of equal license level;
  - A joint Provincial Health Human Resources Coordination Centre (PHHRC) – Bargaining Association consultation forum on health human resources issues, including retention, mental health, and the implementation of the *In Plain Sight* report;
  - A commitment for BCEHS to phase out the Scheduled-on-Call model by March 31, 2024.
- A Regular Part-time Mix-shift to improve coverage in rural and remote locations:
  - 0.75 FTE Regular part-time positions consisting of four regularly scheduled 12-hour shifts (two 12-hour day and two 12-hour night shifts consisting of 4 scheduled working hours and 8 pager hours). The four shifts are followed by four consecutive days off.
- Indigenous Specific Anti-racism initiatives:
  - A provincial forum for dialogue on reconciliation between unions, HEABC, and Indigenous and other leaders within the health authorities;
  - Five days of paid leave for cultural events;
  - The addition of Indigenous definitions of immediate family to the terms of bereavement and cultural leaves.
- Diversity, Equity and Inclusion (DEI) initiatives
  - The establishment of a provincial DEI working group led by PHHRC and including representatives from health authorities, HEABC, and health-sector bargaining associations.

LAST UPDATED

The content of this fact sheet is current as of February 28, 2023, as confirmed by Evan Howatson, Labour and Agreements Branch.

APPROVALS

2023 03 01 - Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 09 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Associate Physicians

Topic: Introduction of the 'associate physician' class of restricted licensure under the bylaws of the College of Physicians and Surgeons of BC (CPSBC) for international medical graduates (IMGs) who are not eligible for a full or provisional license.

Key Messaging and Recommended Response:

- **In November, we announced new pathways for internationally trained physician's to enter BC's workforce – including the new Associate Physician class.**
- **Our objective is to reduce barriers for IMG's while ensuring all physicians practicing in the province have the education and skills to provide the high-quality health care British Columbians deserve.**
- **The new Associate Physicans classification provides a route for international medical graduates (who are not otherwise eligible for licensure as independent medical practitioners) to work under physician direction and supervision within a health authority acute-care setting.**
- **We are currently working with CPSBC to expand the scope of the new class, so that Associate Physicians can work in community-based primary care settings over the coming months.**
- **Previously, internationally trained physicians could not contribute to the health-care system using their medical training and experience, unless they gained a residency position or, for eligible family physicians, completion of the Practice Ready Assessment program.**
- **Now, foreign trained physicians can have a meaningful career helping meet BC's health care and human resource needs as an Associate Physician whether or not they decide to pursue full licensure.**
- **Introducing this new classification of Associate Physicians is just one of many actions we are taking to increase health system capacity and service delivery in the province, ensuring that the people in BC receive the care that they need.**

CURRENT SITUATION

- Health authorities have developed program plans to introduce associate physicians into their workforce. Initial implementation is in accredited, health-authority (HA)-based acute care programs.
- There are 39 acute care associate physician programs in various stages of planning and implementation.

- Prior to initiating recruitment, each clinical program area within a HA that seeks to employ an associate physician must first be accredited by the CPSBC.
- Accrediation requirements include: developing institutional oversight and supervision structures, job description design, establishing a performance evaluation system, and developing continuing professional development processes.
- As of January 31, 2023, six associate physician programs have been accredited by CPSBC:
    - Provincial Health Services Authority (PHSA) – BC Children's Hospital (BCCH):
        - Pediatrics - Clinical Teaching Unit (CTU)
        - Neonatal Intensive Care (NICU)
        - Pediatric Intensive Care (PICU)
        - Surgery
        - Pediatrics – Gastroenterology (GI)
    - Providence Health Care (PHC) – St. Paul's Hospital (SPH)
        - Inpatient Medical and Surgical Program
- As of January 31, 2023, three CPSBC-accreditations assessments are in-progress:
    - Fraser Health Authority
        - Obstetrics at Surrey Memorial Hospital
        - Vascular Surgery at Royal Columbian Hospital
        - Sugical Oncology at Royal Columbian Hospital
- Open employment opportunities are currently posted on the Health Match BC (HMBC) website.
- The Ministry is tartgeting to have over 100 associate physicians hired by the end of 2023.
- As of January 31, 2023, one associate physician has been hired, four employment offers have been made subject to licensure, and ten candidates have been shortlisted for open positions.
- The CPSBC Bylaw amendments to enable expansion into community primary care settings were brought into force on January 13, 2023. Structures to support expansion into community settings are in development in collaboration with the CPSBC and health system partners.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Associate Physicians – Acute Care

- On May 29, 2020, the CPSBC amended their bylaws to create a registration category for associate physicians. Upon creation, this category was limited to practitioners in acute care settings.
- This category of restricted licensure provides a pathway for eligible practitioners who have a medical degree, passed Part 1 of the Medical Council of Canada's qualifying exam (or CPSBC approved equivalent), complete a minimum of two years accredited training as a medical or surgical specialist, HA-sponsorship, and meet all other qualifications required by the CPSBC, but who do not meet the criteria for full or provisional licensure in BC.
- The associate physician class of restricted licensure supports an employment environment for IMGs, who do not meet the criteria for licensure as independent medical practioners, to work under physician direction and supervision to increase healthcare capacity and service delivery.
- The associate physician role is comparable, to varying degrees, to the 'clinical assistant' role in Alberta, Manitoba, and Nova Scotia.
- Throughout 2020/21, the Ministry worked in partnership with the CPSBC, the Health Employers Association of BC (HEABC), HMBC and HAs to develop the policies, processes, and structures needed to support the implementation of associate physicians into acute care settings in BC, including:
    - Development of CPSBC registration policies and accreditation standards
    - Establishing a compensation framework and employment model
    - Candidate screening and recruitment processes

    - Stakeholder engagement
- In September 2022, enhanced supports were made available for HAs through HEABC to help streamline and accelerate program development and implementation.

Associate Physicians – Community Primary Care

- On January 13, 2023, the CPSBC amended their bylaws to expand the associate physician class of registration to include community primary care.
- This category of registration provides a pathway for eligible practitioners who have a medical degree, passed Part 1 of the Medical Council of Canada's qualifying exam (or CPSBC approved equivalent), complete a minimum of one years accredited training as a general practioner, HA-sponsorship, and meet all other qualifications required by the CPSBC, but who do not meet the criteria for full or provisional licensure in BC.
- Structures to support expansion into community primary care settings are currently in development. This includes establishing an employment and compensation model as well as a regulatory framework with supporting policies on clinical supervision.

International Medical Graduates

- IMGs are individuals who have obtained their medical education from medical schools (listed in the World Directory of Medical Schools) outside of Canada.
- Medical education varies widely among IMGs due, in part, to the varied selection, evaluation and credentialing processes in place at different international medical schools.
- Canadian medical regulators at national and provincial levels determine the medical credentials and qualifications to practice in Canada and must ensure that every internationally trained applicant meets these standards.
- For IMGs with training that does not meet the requirements for independent medical practice and do not wish to redo postgraduate medical education (PGME or residency), the associate physician class of registration supports an employment environment to work under physician supervision within team-based settings (also see 'Pathways to Practice for Internationally Educated Physicians' Fact Sheet).

LAST UPDATED

The content of this fact sheet is current as of February 16, 2023, as confirmed by Kevin Brown, Executive Director, Physician Services Branch.

APPROVALS

2023 02 22 – Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

CUAET MSP Updates

Topic: Due to the on-going conflict in Ukraine, BC continues to see the arrival of individuals fleeing Ukraine as new or returning Canadian citizens, individuals with permanent resident status, and deemed residents including those arriving under the Canada-Ukraine Authorization for Emergency Travel (CUAET).

Key Messaging and Recommended Response:

- **Our government is committed to providing Medical Services Plan (MSP) coverage to individuals arriving from Ukraine who are Canadian citizens, permanent residents, or deemed residents, including those arriving under the Canada-Ukraine Authorization for Emergency Travel (CUAET).**
- **Effective on the first day of the month in which their application for MSP enrolment is submitted, these individuals will be provided MSP coverage, and if required and requested, backdated coverage to their date of arrival will be available.**
- **The Ministry of Health continues to monitor MSP enrolment and review the associated demographic data. This data is shared with Immigration Services and Strategic Planning Division, Ministry of Municipal Affair, as an indication of CUAET settlement in the province.**
- **As of December 27, 2022, a total of 10,375 individuals from Ukraine have completed enrolment with MSP, 9,604 of whom arrived under CUAET.**
- **In addition, the Canada-Ukraine Authorization for Emergency Travel International Student Health Fee Remission Regulation was enacted in December 2022 to support international students who are enrolled in MSP under a CUAET study permit by waiving any International Student Health Fee (ISHF) debt they may have incurred since March 1, 2022.**
- **We will continue to closely monitor the situation and proactively update MSP coverage and services to support the needs of individuals arriving under CUAET, ensuring they receive the necessary health care during their settlement in the province.**

CURRENT SITUATION

- Individuals from Ukraine who arrive in BC as Canadian citizens, Permanent Residents, or deemed residents (including those who arrived through the CUAET) will be provided Medical Services Plan (MSP) coverage effective on the first day of the month in which their application for MSP enrolment is submitted.

- If required and requested, backdated coverage to their date of arrival (if different from the month in which their MSP application was submitted) will be available.
- The Ministry of Health continues to monitor MSP enrolment and review the associated demographic data. This data is shared with Immigration Services and Strategic Planning Division, Ministry of Municipal Affair, as an indication of CUAET settlement in the province.
- As of December 27, 2022, a total of 10,375 individuals from Ukraine have completed enrolment with the Medical Services Plan (9,604 arrived under CUAET), of which 409 held a Study Permit with CUAET remarks.[1]
- Settlement patterns remain relatively steady. As of December 16, 2023, 42% of 9,261 CUAET arrivals (meeting data linkage requirements) continue to settle in Fraser Health Authority, 31% in Vancouver Coastal Health Authority, 12% in Vancouver Island Health Authority, 12% in Interior Health Authority, 4% in Northern Health Authority.[2]
- Of arrivals, 57% are female, 43% are male, and the average household is 2.4 individuals based on address.[3]

FINANCIAL IMPLICATIONS

The cost of MSP coverage for those who are enrolled in MSP with a valid CUAET document continues to be tracked and monitored.

KEY BACKGROUND

- Under the *Medicare Protection Act* (the Act), an individual must meet the definition of a resident to be eligible for MSP coverage.
- A resident is defined as a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes their home in BC, and is physically present in BC for at least six months in a calendar year, or a shorter prescribed period. This includes a person who is deemed under the Medical and Health Care Services Regulation to be a resident but does not include a tourist or visitor to BC.

<u>Waiver of the MSP Coverage Wait Period</u>

- On March 7, 2022, the Medical Services Commission approved a waiver of the wait period for returning Canadians, permanent residents and deemed residents arriving from Ukraine. As such, those arriving from Ukraine under the CUAET will be eligible for day of arrival coverage as deemed residents once a completed application for MSP enrolment has been submitted to HIBC with supporting documentation (e.g., a CUAET Temporary Resident Visa and/or work permit).

<u>Amendment to the Medical and Health Care Services Regulation</u>

- The Medical and Health Care Services Regulation was amended on April 22, 2022, to include individuals arriving in BC under the CUAET as deemed residents.
- Prior to the update, only those who arrived under CUAET who were issued a work or study permit valid for six months or more would be eligible for MSP enrolment.
- The amendment allows MSP enrolment for those who are issued only a CUAET Temporary Resident Visa/Visitor Visa.

<u>CUAET Medical Test</u>

- The Ministry of Health will fund the cost of the federally mandated medical examination that may be required for individuals who arrive in BC under CUAET.
- Effective October 1, 2022, individuals who are enrolled in MSP and who must complete the federal medical exam or diagnostic services should not receive a bill. Practitioners and diagnostic facilities can bill the Ministry of Health directly.
- MSP beneficiaries enrolled with a CUAET document who have already paid for the services can request reimbursement.

[1] Health Insurance BC CUAET Policy Impact Volumes 28 December 2022.
[2] HSIAR RMS2560 Summary Data 2023-01-11.
[3] HSIAR RMS2560 Summary Data 2023-01-11.

- The Ministry of Health continues to track and monitor reimbursements to beneficiaries and payment for the CUAET medical exam or diagnostic services.

International Student Health Fee

- Individuals arriving under CUAET may hold a Visitor Record, Study Permit, Work Permit or Temporary Resident Permit (these are considered status documents).
- In September 2019, the International Student Health Fee (ISHF) was introduced for international students enrolled in MSP with a study permit for six months or longer.
- ISHF is billable to anyone enrolled in MSP under a valid study permit. The fee is authorized by a directive of the Financial Administration Act (FAA), and there was no ability to waive the fee for individual circumstances.
- With some exceptions, the Ministry of Finance did not send out bills to individuals enrolled in MSP with a CUAET study permit, however, debt continued to accrue.
- A small number of bills were initially sent out, before the Ministry of Finance held billings.
- Accrued debt was visible to BC residents through the Revenue Services of BC Columbia Billing and Payment Services online portal.
- On December 19, 2022, the Canada-Ukraine Authorization for Emergency Travel International Student Health Fee Remission Regulation (Regulation) was enacted.
- The regulation applies remission to ISHF debt, accrued from March 1, 2022, onward for individuals enrolled in MSP under a CUAET study permit.
- If a refund is owed, the Ministry of Finance will be contacting individuals directly regarding their refund.
- The resulting accrued debt visible on the RSBC Billing and Payment Services online portal will be removed once the remission process takes place.

LAST UPDATED

The content of this fact sheet is current as of February 3, 2023 as confirmed by Stephanie Power, Executive Director.

APPROVALS

2023 02 12 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Extra Billing – *Canada Health Act*

Topic: The *Canada Health Act* establishes criteria provinces must meet with respect to "insured health services" (which include any medically required services of hospitals and medical practitioners) in order to receive full federal transfer payments. The *Canada Health* Act explicitly prohibits user fees and "extra billing" of patients for "insured services" and requires the federal government to deduct an amount equal to such charges from Canada Health Transfer (CHT) payments to a province involved.

Key Messaging and Recommended Response:

- **One of the most critical roles of the Minister of Health, and indeed of the Medical Services Commission, is ensuring access to healthcare is not based on anyone's ability to pay.**
- **That is why we changed the *Medicare Protection Act* in 2018, bringing in provisions that included new protections for patients ensuring they would not be liable for extra billing, clarifying rules around extra billing for medical practitioners, and setting out consequences for those who break the rules.**
- **It's illegal for private clinics to charge any additional fees for services that are insured benefits of MSP or hospital services under the *Hospital Insurance Act*. To allow such extra billing of patients is a violation of the legislation.**
- **Any contracts awarded to private clinics come with the expectation the clinic follows the *Medicare Protection Act* (MPA).**
- **When clinics are not compliant with the MPA, their contract may be suspended, and they are referred to BC's Medical Services Commission.**
- **The province is firmly committed to maintaining the integrity of public healthcare in BC and stands resolutely against any privatization of publicly insured services.**
- **For example, for over a decade, the province has defended the public healthcare system in Canada through the ongoing Cambie Surgeries Centre litigation. The province has been successful in two levels of provincial court.**

CURRENT SITUATION

- The *Canada Health Act* requires provinces to submit a financial statement each December showing the amount charged to patients through extra billing and/or user charges for the fiscal year ending 21 months previously (e.g., December 2022 for 2020/21).

- In last year's report for 2020/21, the amount of Extra Billing and User Charges reported by BC to Health Canada was $23,110,530.54.
- In March 2022, under Health Canada's Reimbursement Policy, a $20,518,055[1] reimbursement was applied to BC's March 2022 CHT payments, which represents a partial reimbursement of BC's March 2020, March 2021, and March 2022 CHT deductions.
- On September 10, 2020, the BC Supreme Court ruled in the Province's favor in the Cambie Surgeries Corporation v. BC (Attorney General) case.
- On December 8, 2020 the Court of Appeal issued a limited form of injunction which prohibited the Medical Services Commission (MSC) from exercising its powers of enforcement under sections 21(2) and (3), 45.1 and 46(5.1) and (5.2) of the *Medicare Protection Act* (MPA)for any private surgeries where a patient has been scheduled for a date beyond the Ministry of Health wait time benchmarks or where a surgery has not taken place by the date set according to such wait time benchmarks. This injunction expired on September 30, 2021.
- On July 15, 2022, the BC Court of Appeal upheld the BC Supreme Court decision. On September 29, 2022 the Plaintiffs applied for leave to appeal to the Supreme Court of Canada. The Province filed its response to this application on November 25, 2022.
- On April 1, 2020, the Federal Diagnostics Services Policy came into effect. This policy aims to ensure patients do not face charges for medically necessary diagnostic services such as (but not limited to) magnetic resonance imaging (MRI) and computed tomography (CT) scans, regardless of where the services are provided. As of April 1, 2020, any province that has not eliminated patient charges for medically necessary diagnostic scans is subject to mandatory deductions under the terms of the *Canada Health Act*. Reports to Health Canada on extra billing and user charges in respect of medically necessary diagnostic services began in this year's report in December 2022 with a total of $17,165,309 etra-billing charged reported.
- Advice/Recommentations

FINANCIAL IMPLICATIONS

BC's requirement to report on extra billing and/or user charges annually to Health Canada results in a reduction to federal government Canada Health Transfer payments.

KEY BACKGROUND

- Amounts reported by BC to Health Canada and corresponding federal deductions:

Fiscal Year	Reported Patient Charges	Result of Onsite Audits	Charges related to medically necessary diagnostic services	Additional Health Canada Assessment*	Total
2020/21	$157	$5,945,064.04**	$17,165,309		$23,110,530.54
2019/20	$95	$13,275,728			$13,275,823
2018/19	$200	$13,949,779			$13,949,979
2017/18	$1,561	$16,752,272			$16,753,833
2016/17	$7,533	$16,169,726			$16,177,259
2015/16	$1,980	$592,173		$174,493	$768,646
2014/15	$10,015			$174,493	$184,508
2013/14	$29,652			$174,493	$204,145
2012/13	$67,144			$174,493	$241,637
2011/12	$50,075			$174,493	$224,568
2010/11	$105,526			$174,493	$280,019

*based on specific findings in Cambie Surgery Centre

**includes $70,640.94 in charges found to be non-compliant with the Cambie Injunction

[1] March 18, 2022 email from Gigi Mandy (Health Canada) to Stephanie Power (BC Ministry of Health).

- Reported extra billing has generally been associated with private surgical facilities or specialist consultation services, with the addition of reporting on extra-billing in diagnostic facilities in December 2022.
- On behalf of the MSC, the Ministry's Beneficiary and Diagnostic Services Branch reviews alleged cases of extra billing brought to its attention. Unresolved cases are referred to the Commission for further review and/or action.
- In 2020/21 there were a total of 5 patient complaints where extra-billing was determined to have likely occurred. In 4 of the 5 cases, the Ministry was successful in obtaining reimbursement for the patient.
- The next annual report for Health Canada is due in December 2023.

LAST UPDATED

The content of this fact sheet is current as of April 5, 2023 as confirmed by Stephanie Power, Executive Director, Beneficiary and Diagnostics Sevices.

APPROVALS

2023 02 14 – Anne Schuetze obo Rob Byers, Finance and Corporate Services Division
2023 04 18 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Care Assistants

Topic: The Ministry of Health (MOH) actively and financially supports the development and sustainability of the Health Care Assistant (HCA) workforce in BC.

Key Messaging and Recommended Response:

- **The BC Care Aide and community Health Worker Registry provides oversight to Health Care Assistants (HCA). To be eligible to work as an HCA in any publicly funded health care setting in BC, applicants must have registered with the Registry. As of December 2022, there were 46,265 active HCA registrants.**
- **We've made significant investments in health care assistant education, recruitment and retention which will build the workforce and decrease pressure on current staff:**
    - **In 2019 the Ministry of Health in collaboration with several stakeholders launched the Choose2Care campaign is to increase public awareness of the HCA profession.**
    - **In January 2020 we implemented the HCA Expedited Registration Pathway for Canadian out of province (OOP) HCAs which ensured effective, efficient registration for qualified OOP HCAs.**
    - **To support long term care staffing needs due to COVID-19, the MoH initiated a pilot with the Registry to expedite the registration of internationally educated individuals to become HCAs.**
    - **In 2020, the Ministry of Health initiated the HCA Recruitment Incentive, a one-time payment of $5,000 to eligible applications through the Choose2CareProgram.**
    - **We provided $585 million over three years to support the Health Career Access Program, which aims to train, recruit and employ up to 3,000 entry-level health care workers each year (Budget 2021).**
- **Growing these programs and increasing BC's supply of highly skilled graduates will ensure the province has the right health professionals in the right places so that British Columbians can access the health services they need now and in the future.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- The HCA occupation is unregulated in BC. Oversight is provided by employers and the BC Care Aide & Community Health Worker Registry (Registry). The Registry is a division of the Health Employers Association of BC (HEABC) Recruitment Solutions, which includes Health Match BC (HMBC), Locums for Rural BC, and Practice Ready Assessment BC.
- The Registry's mandate is to protect vulnerable clients and patients under the care of HCAs as well as to develop minimum standards of education and skill among HCAs.
- To be eligible to work as an HCA in any publicly funded health care setting in BC, applicants must be registered with the Registry. HCAs are not currently required to be registered on the Registry to work in a private organization.
- As of December 1, 2022, there were 46,265 active HCA registrants on the Registry.[1]
- As per guidance developed in collaboration between the MOH and the Ministry of Post Secondary Education and Future Skills (PSFS), a review of the HCA Curriculum Guide (2015) takes place every five years to ensure that content remains aligned with the current HCA Core Competency Profile (2014). The anticipated date for completion is June 2023.
- In January 2023, a working group commenced to review the HCA Core Competency Profile to ensure alignment with both the refreshed curriculum and the newly published National Occupational Standard for Personal Care Providers (November 2022).
- MoH has received several requests over the years from stakeholders, including employers and seniors' advocates, to expand the HCA role. However, there are no formal plans to make changes to the framework overseeing HCAs in BC at this time. If any formal activity is initiated to change or expand the role of HCAs, the MoH will engage all necessary and appropriate stakeholders.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- HCAs are direct care providers that work in acute care, long term care and assisted living, group homes, and community care. Working as part of a health care team and receiving direction and supervision from regulated health professionals, HCAs are trained to provide personal care assistance and supports to older adults, people living with disabilities and/or chronic illnesses, and clients receiving palliative care. Duties include client mobility supports, daily living activities, and personal care.
- The Registry recognizes both public and private HCA educational and training programs.[2] Currently, there are 31 recognized programs at 77 locations across BC (15 private and 16 public colleges).[3]
- The Alberta Health Services created the role of Comfort Care Aides (CCAs) to offset staffing shortages in care facilities which were increased due to the COVID-19 pandemic. The Good Samaritan Society is the only operator in BC that employs CCAs.[4]

<u>HCA Education</u>

- HCA programs are typically 8 months (with an additional 12 weeks for programs offering an HCA ESL variation). On average, BC HCA programs offer two student intakes per year.[5]
- The Health Careers Access Program (HCAP) was developed as a work-integrated learning pathway that introduces the role of health care support worker (HCSW) and leads to full HCA certification. HCAP follows established Provincial standards and applicants who are accepted into the program receive a comprehensive 2-week, provincially standardized orientation. The HCAP Partnership Pathway (HCAP-PP) program offers 2 model frameworks to HCSWs enrolled in the program:
    - part-time modular model - students split weekly time between work and education

[1] Data received from BC Care Aide & CHW Registry, January 2023.
[2] BC Care Aide & CHW Registry, https://www.cachwr.bc.ca/About-the-Registry/List-of-HCA-programs-in-BC.aspx.
[3] Data received from PSFS September 1, 2022
[4] Question raised by MLA Ashton, MoH Estimates, Second Session, 42nd Parliament, June 8, 2021, Afternoon Sitting.
[5] Information confirmed by PSFS January 31, 2023

- block modular model-students undertake alternating work/education program modules. (see *Health Career Access Program* Fact Sheet).

HCA Strategies

- In 2019 the MoH implemented the Provincial Marketing and Recruitment Strategy in collaboration with HEABC, BC College of Nurses and Midwives and HMBC to generate an estimated 200 net new HCAs in 3 years. The Choose2Care campaign was launched by HMBC through this strategy, which included the development of a website as well as print, transit, community media, digital/social media to drive visitors to the website.[6] The purpose of Choose2Care is to increase public awareness of the HCA profession and to provide potential HCAs with the information they need to train, register, and become employed.
- In November 2019 the Minister announced the HCA Expedited Registration Pathway for Canadian out of province (OOP) HCAs. This pathway was implemented in January 2020 and ensured effective, efficient registration for qualified OOP HCAs/equivalent workers.
- To support long term care staffing needs due to COVID-19, MoH initiated a pilot with the Registry to expedite the registration of internationally educated individuals to become HCAs. Since the pilot began in December 2020 to the end of Q3 FY 2022-23, there have been a total of 117 applicants that have qualified and 111 (95%) have successfully registered.[7]
- In 2020, COVID-19 increased the need for HCAs in long-term care and assisted living settings across BC. HCAP was implemented to provide a path for applicants with no health care experience to get hired as HCSWs and receive paid employer sponsored health care assistant training as part of their employment (See "Health Career Access Program Fact Sheet" for more information).
- In 2020, MOH initiated the HCA Recruitment Incentive (RI), a one-time payment of $5,000 to eligible applications through HMBC Choose2CareProgram (HEABC). With applications closing on August 31, 2022, the overall total number of applicants who received the HCA RI was 2,511 and the total amount disbursed was $12,555,000.[8]

LAST UPDATED

The content of this fact sheet is current as of Februay 14, 2023 as confirmed by Zachary Matieschyn, ED, Nursing Policy Secretariate Branch.

APPROVALS

2023 02 25 - Mark Armitage, Health Sector Workforce and Beneficary Services Division

[6] Cliff# 1115957 BN, Advancing HCAs Education, Recruitment and Retention, Signed by the DM on Sept 18, 2018.
[7] Data received from BC Care Aide & CHW Registry, January 31, 2023
[8] HEABC Q2 FY 2022-23 Report.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Career Access Program

Topic: Government announced the Health Career Access Program (HCAP) on September 9, 2020[1] to provide a flexible pathway to rewarding careers in healthcare while taking decisive action to address persistent staffing challenges in the long-term care, assisted living, and home support sectors. This program enables the recruitment of over 3,000 entry-level health care workers annually in long-term care (LTC) homes, assisted living (AL) facilities, and health authority owned and operated home health services and acute care across the province. Participants begin working as Health Care Support Workers (HCSWs) and receive publicly funded, employer-sponsored training leading to full qualification as a health care assistant (HCA).

Key Messaging and Recommended Response:

- **Government is taking action to recruit over 3,000 entry level health-care workers annually into the health sector.**
- **The Health Career Access Program provides a flexible pathway to a rewarding career in health care.**
- **This program is part of the Province's Health Human Resources Strategy which works to strengthen BC's health workforce through retention, recruitment and training, as well as redesigning the health-care system.**
- **The Health Career Access Program allows participants to begin working as health care support workers while upgrading their skills to become licensed health care assistants, which helps remove financial barriers to furthering their education.**
- **Since the program was announced on September 9, 2020, 5,192 positions in the Health Career Access Program have been filled.**
- **As more health-care workers join the work force, they will be able to spend more time with their patients, resulting in better care.**
- **The program is supported by over $117 million in funding as part of Budget 2023.**

CURRENT SITUATION

- On September 9, 2020, Government announced the hiring of 7,000 individuals into the health sector over three initiatives including creating 3,000 net new HCSW FTEs.[2]

[1] BC Government News Release Sept.9, 2020: https://news.gov.bc.ca/releases/2020PREM0050-001694

- As of April 18, 2023, a total of 5,523 HCAP positions have been filled[2]:
  - 4,529 for HCAP in health authority, private, and affiliate LTC/AL settings
  - 909 for HCAP in health authority home health settings
  - 85 for HCAP in acute care settings
  - 1521 to support visitation and 1945 to fill existing vacancies in LTC/AL (programs complete)
- As of April 18, 2023, 3,485 HCAP participants have started their training at a post secondary institution, with 2,373 having graduated from their HCA education program. [3]

Table 1 HCAP Hiring Activity as of April 18, 2023

	Allocation	Total Hires
LTC/AL Sites	**4,922**	**4,529**
Health Authority Sites	*2,008*	*1825*
Private/Affiliate	*2,914*	*2,704*
Home Support	**1,059**	**909**
Acute Care	**87**	**85**
Total	**6,068**	**5,523**

- An expansion into acute care, supporting a new team-based care model in Emergency Departments, is being prototyped across all Health Authorities as of April 1, 2023. An early prototype in the Fraser Health Authority hired 66 participants. An additional 19 HCAP acute participants have been hired to the Interior Health Authority.
- The first prototype expanding HCAP into Indigenous communities initiated in May 2022. Several additional First Nations communities have expressed interest in participating with hires planned throughout 2023.

FINANCIAL IMPLICATIONS

- Budget 2021 provided $585 million over three years to continue support of the HCAP program.
- In 2022/23, $117 million was provided to the health authorities for wage and benefit supports and $900,000 for administrative supports while individuals train as health-care workers in long-term care homes and assisted-living facilities throughout BC.
- A further $3 million was provided in 2020/21, $4.2 million in 2021/22, and $2.7 million in 2022/23 to the Ministry of Post-Secondary Education and Future Skills (PSFS) to support direct program funding to post-secondary institutions.
- PSFS received funding for 600 HCAP training seats in 2020/21 (914 seats were funded into 21/22) and a further 2,400 through Budget 2021 (3,020 seats were funded into 22/23). PSFS received additional funding through Budget 2022 to support 1,950 HCAP seats.

KEY BACKGROUND

Program Overview

- HCAP provides a publicly funded, work-integrated learning pathway for participants wanting to become health care assistants (HCAs). Participants begin the program as HCSWs with an employer in LTC, AL or home health, and alternate between the work setting and formal study through an approved post secondary institution. Upon completion of the program, participants will be qualified as HCAs and able to register with the BC Care Aide and Community Health Worker Registry.
- While working, HCSWs are supervised by a regulated health professional, and work functions are limited to non-clinical, non-direct care activities.

[2] On September 9, 2020, Government announced the hiring of 7,000 individuals into the health sector over three initiatives including: (1) 3,000 net new Health Care Support Worker (HCSW) FTEs (2) 2,000 net new FTEs to support visitation in long-term care and assisted living and (3) 2,000 existing vacancies filled through the Provincial Recruitment campaign. As of April 18, 2023, 8,989 positions have been filled across three initiatives.
[3] Health Career Access Program (HCAP) Portal, April 18, 2023.

- The purpose of HCAP is to:
    - Increase the provincial supply of HCAs by providing participants a low barrier pathway to employment in the health sector.
    - Stabilize and augment staffing in LTC and AL facilities and home health locations by increasing the supply of HCAs while engaging HCSWs in a supportive role focused on non-clinical duties.
    - Facilitate labour market transitions for British Columbians who face unemployment or underemployment due to COVID-19 or other factors.
- All education and employment costs are funded through the program.

Recruitment, Allocation, Matching and Hiring Processes

- Recruitment for HCAP is employer driven. Employers vet and select new HCSW hires from a provincial candidate pool developed through an expression of interest process. In cases where a suitable candidate cannot be located from the pool, employers have flexibility to source candidates through other channels.
- Regional Allocation Plans confirm employer allocations of HCSW positions through the program. Non-health authority employers are then required to sign *Employer Funding Agreements* which provide a description of employer benefits and obligations under the program.

Training

- HCSWs receive a comprehensive two week, provincially standardized orientation, and onboarding program. Following an initial period in the workplace, HCSWs commence a series of formal HCA education modules. These may be taken on a part-time or full-time basis and are interspersed with periods of employment. HCA training is provided by an approved post-secondary institution (PSI).
- The module-based training offered under HCAP is structured to meet the requirements of the standard provincial HCA curriculum and contains lab, practical and theoretical components.

Program Completion

- Once an HCSW has successfully completed their HCA education, they earn a recognized credential that qualifies them to register with the BC Care Aide & Community Health Worker Registry.
- At this time, formal participation with HCAP ends and participants are qualified to register as HCA.
- Participants will be employed as HCAs and, in most cases, will work through a 12-month return of service to fulfill their commitments to the program.

LAST UPDATED

The content of this fact sheet is current as of April 20, 2023 as confirmed by Melissa Murdock obo Zachary Matieschyn, ED, Nursing Policy Secretariat Branch.

APPROVALS

2023 03 24 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 22 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Education Expansion

Topic: To outline the comprehensive investments in health education expansion.

Key Messaging and Recommended Response:

- **This government is focused on new education programs. These include more than 20 different health occupations, from nurses to midwives to medical laboratory technologists to paramedics. For example:**
  - **The addition of 322 new ongoing allied health seats across BC's public post-secondary institutions**
  - **The further expansion of UBC's medical school (beginning in 2023) and its postgraduate medical residency training programs to deliver a combined 128 new seats annually.**
- **We have also invested in programs that remove financial barriers to people who want advance their careers or start working in BC some of these initiatives include:**
  - **$12 million investment to support internationally educated nurses (IEN) by simplifying the application and assessment processes for IEN candidates**
  - **$9M in bursaries to remove financial barriers to assessment for IENs and nurses returning to practice**
  - **$3 million in funding to provide financial support to Health Care Assistants (HCAs) who want to advance their careers and develop skills to become licensed practical nurses (LPNs).**
  - **$585 million over three years to support the Health Career Access Program, which aims to train, recruit and employ up to 3,000 entry-level health care workers each year (budget 2021)**
    - **As of February 2023, a total of more than 5,000 applicants have been hired and over 2,000 students have graduated.**
- **These are just some of the many actions we are taking to ensure that we have the healthcare workforce required to ensure that British Columbians receive access to the care they need.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

Nursing and Midwives

- In 2022, the Province announced an expansion of 602 new nursing seats to colleges and universities around BC – adding to the approximate 2,000 existing nursing seats in the province.
    - 362 registered nursing seats, 40 registered psychiatric nursing seats, 20 nurse practitioner seats and 180 licensed practical nurse seats at 17 public post-secondary institutions
    - an additional Spring intake (35 seats) for the Kwantlen Polytechnic University Graduate Nurse Re-Entry Program for Internationally Educated Nurses
- Since 2017, the Province has more than doubled the nurse practitioner seats, with a 46% increase in practical nursing seats and 22% increase in Bachelor of Nursing seats.
- The Province is adding 20 seats to the University of BC's midwifery program, bringing the total annual intake to 48; 12 seats to the Bachelor of Midwifery program and and 8 seats to the Internationally Educated Midwives Bridging Program.
- Government provided 1.1 M in funding for start up of the first nursing degree program in the Northeast region of BC in Fort St. John. The program launched in Fall 2021 supports recruitment and retention of nurses in the North[1].
- Government also provided approximately $8.7 million in 2021-22 to support health educational training programs, including the expansion of specialty nursing education to to 1,000 seats annually.
- To meet the increasing demand for nurses, BC recently launched new supports and bursaries to make it easier for eligible internationally educated nurses to enter the province's health system so they can support British Columbians' health care needs sooner.
- The Province also announced a bursary for HCAs looking to accelerlerate their training as an LPN, by providing up to $10,000 towards publicly funded Access to Practical Nursing programs.

Allied Health

- Up to 322 new allied health seats across 22 different post-secondary institutions were announced on July 19th, 2022, to help address allied health workforce needs across the province.
- This includes both on going and one-time funded seats to targeted areas ranging from medical laboratory technology, medical laboratory assistants and technologists, pharmacy technicians, occupational and physical therapy programs, social work and the development of an Advanced Care Paramedic Bridging program at the Justice Institute of BC to help prepare paramedics trained outside of BC enter the workforce.
    - Samples of ongoing seat expansion funding include: occupational therapists: 32 seats (16 seats in 2023 and 16 seats in 2026); physiotherapists: 40 seats (20 seats in 2024 and 20 in 2026); rehabilitation assistants: 40 seats (20 in 2023 and 20 in 2024); social workers: 25 seats (10 in 2022 and 15 in 2023); medical laboratory technologists: 28 seats (16 seats in 2022 and 12 seats in 2023).
    - Samples of one-time seat expansion funding include: medical laboratory assistants: 24 seats at Vancouver Community College in May 2022, with student supports at Camosun College for January and September 2022 intakes, and regional distribution of Thompson Rivers University's medical laboratory assistant program through 2022; respiratory therapists: as many as 20 additional fast track seats at Thompson Rivers University in September 2021 and 2022.
    - Physical Therapy: $24.9 million into the purchase and renovation of new program space in Surrey so that the University of BC can expand its masters of physical therapy program in the Fraser region supporting 20 new physical therapy seats available this fall, with those students moving to the new location in Surrey when it opens in 2023.

Health Care Assistants (HCAP)

- The Health Care Assistant Partnership Pathway (HCA-PP) is the Health Care Assistant (HCA) education component of the Health Career Access Program (HCAP).
  Through Budget 2021, $30.2 million was allocated through the Ministry of Post-Secondary Education and Future Skills (PSFS) budget to fund 2,400 HCA education seats as part of HCAP; PSFS was also allocated

[1] https://news.gov.bc.ca/releases/2019AEST0070-001195

funding for 600 training seats in 2020/21 by way of Contingencies access, as well as additional funding through Budget 2022 to support 1,950 HCAP seats

- There are over 830 HCA-PP seats currently in progress with 76 seats scheduled to start by the end of this Fiscal and another 500 seats to start in Fiscal year 2023/24. PSFS is working with PSIs to schedule additional HCA-PP cohorts for the 2023/24 Fiscal year.
- To date, a total of more than 5,000 applicants have been hired and over 2,000 students have graduated.
- This program is supported through investments in education of almost $64 million, since 2020.

Physicians

- Between 2017 and 2022, HLTH allocated additional funding to support the expansion of over 60 new annual residency positions within key areas that include anesthesiology, family medicine, geriatrics, emergency medicine, palliative care, pediatrics, psychiatry and addictions, maternity, and cancer care.
- Beginning in 2023, the Province is also supporting further expansion of UBC's medical school and its postgraduate medical residency training programs to deliver a combined 128 new seats annually.
    - 40 total additional undergraduate medical school seats will be phased-in over 2023/24 and 2024/25, to a total of 328 per year, a 14% increase above the current 288 intake.

Advice/Recommentations

- HLTH continues to support the Ministry of PSFS's mandate to launch a new Simon Fraser University medical program based in Surrey, with the aim to accept its first students by September 2026.

FINANCIAL IMPLICATIONS

- Budget 2021 announced $96M over 3 years to support training in health sector human resources. This includes $30.2 million for training as part of the Health Career Access Program (HCAP), and $65.8M in new health program funding over 3 years.
- Program expansions for nursing and allied health programs started as early as Fall 2021, with many more program expansions already underway.
- Budget 2022 includes $6.9M to continue to deliver on health program expansions committed through Budget 2021, along with a further $25M for an additional 2,000 Health Career Access Program training seats.

KEY BACKGROUND

- Health care is one of the fastest growing fields of employment in BC and is an important part of a strong, resilient economy.
- The Post-Secondary Education and Future Skills (PSFS) works with the Ministry of Health (HLTH) and Post-Secondary Institutions (PSIs) to make sure health education needs are aligned with current and future health workforce needs in BC.
- Training more health care providers and preparing them to enter the workforce is just one factor in meeting health workforce needs in BC.

LAST UPDATED

The content of this fact sheet is current as of February 22, 2023, as confirmed by Miranda Mason, Health Workforce Planning and Implementation Branch.

APPROVALS

2023 02 22 – Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 07 –Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Professions and Occupations Act

Topic: An independent inquiry into the *Health Professions Act* (HPA) found that the HPA does not fully enable modern ways of regulating health professionals. New legislation called the *Health Professions and Occupations Act* received royal assent on November 24, 2022 and will come into force through regulation at a future date.

Key Messaging and Recommended Response:

- **This legislation is about keeping people safe. That's always been the role of regulatory colleges and that's what this legislation allows us to do better. It takes a proactive approach to eliminating discrimination in BC's health care system.**
- **The HPOA came out of a very significant report conducted by an expert in the field of health profession regulation, Harry Cayton. The report was the result of an inquiry into possible approaches to modernize BC's overall health regulatory framework and an inquiry into the College of Dental Surgeons of BC.**
- **As Harry Cayton said after reviewing the current regulatory model, "Unlimited self regulation has in general proved itself unable to keep patients safe or to adapt to changing healthcare provision and changing public expectations. Professional regulation needs to be shared between the profession and the public in the interests of society as a whole." We are addressing this with the new changes in the HPOA.**

If asked about college boards

- **The HPOA improves governance of regulatory colleges by moving to a merit and competency-based appointment process of college boards, conducted by an independent office led by a Superintendent.**
- **The Superintendent will consult on, and publish guidelines for selecting candidates. This process will be made public by the superintendent and will INCREASE accountability, independence, and transparency.**

If asked about the consulation process

- **The consultation process that occurred for the HPOA was one of the most thorough consultation and engagement processes that the government has**

ever offered including public enagement, stakeholder engagement (regulatory colleges and associations), and Indigenous partners.

If asked if HPOA will regulate what physicans say

- **This is not true. This legislation is not about limiting critical or free speech of health care professionals, but it is about limiting speech that could bring harm to the public.**
- **The aim of this Act is to protect the public from the small number of unethical or incompetent health professionals that can erode public trust in the excellent professionals providing excellent care everyday and ensure that BC's healthcare system continues to provide the best possible care to the families that live in this province.**

CURRENT SITUATION

- The *Health Professions and Occupations Act* received royal assent on November 24, 2022, and plans are being worked on to bring this Act into force through Order in Council.
- Advice/Recommentations; Cabinet Confidences

FINANCIAL IMPLICATIONS

The annual cost of the oversight body and the estimated cost of amalgamation of the 11 colleges into two umbrella colleges are to be determined.

KEY BACKGROUND

Cayton Report

- On April 11, 2019, the Minister released the report: *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (the Cayton Report).
- In response to the suggestions in the Cayton report, the Minister established and chaired the multi-party steering committee to develop a proposal on modernizing the regulatory framework for health professions in BC. Committee members included MLA Norm Letnick and MLA Sonia Furstenau.
- The steering committee reviewed the Cayton Report's suggestions and feedback received in a first round of public consultation (which closed June 14, 2019) and developed a consultation paper with proposed changes to health profession regulation.
- Public consultation on the proposals contained in the paper was held between November 27, 2019, and January 10, 2020. A total of 4,018 surveys and 1,480 written submissions were received.
- On August 27, 2020, the steering committee released its final recommendations based in part on public consultation, key recommendations from the Cayton report, as well as expert advice.
- The *Health Professions and Occupations Act* received royal assent on November 24, 2022.
- A workplan is being developed to create a roadmap to implement the new legislation.Advice/Recommentations; Cabinet Confidences
  Advice/Recommentations; Cabinet Confidences

- Since the legislation passed royal assent, there has been negative media coverage, most of which includes misinterpretation of what the Act does.

- Several organizations have spoken publicly about their lack of support for the Act. Advice/Recommentations
  Advice/Recommentations

- The greatest concerns voiced are regarding full appointment of regulatory college boards, alleged lack of consultation, and the fear that freedom of speech is being eroded.
- Advice/Recommentations
- In response to public concerns raised by media, associations, and health professionals, Ministry of Health staff have added a "Q&A" section on the *Health Professions and Occupations Act* to the Professional Regulation and Oversight webpage on the BC Government website.
- This addition is intended to enhance clarity around what the Act does, clearly demonstrate the extent of consultation, and debunk some of the more common misinformation.
  Ministry of Health, health profession colleges, employers and others will be directing stakeholders and incoming correspondence to this webpage for more clarity on their concerns.

LAST UPDATED

The content of this fact sheet is current as of February 6, 2023 as confirmed by Mark MacKinnon, ED, Professional Regulation and Oversight Branch.

APPROVALS

2023 02 12 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 02 16 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Sector Sick Leave

Topic: Overview of short-term sick leave rates in the BC health sector and Government actions to support workers needing sick leave.

Key Messaging and Recommended Response:

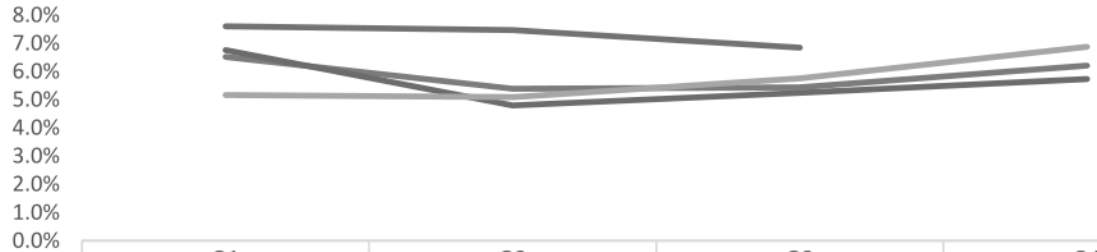
- **The COVID-19 pandemic and respiratory viruses causing illness highlight just how important it is for workers to be able to stay home if they are sick.**
- **No one should have to choose between going to work sick or losing wages. That's why, as of January 1, 2022, BC became the first province in Canada to implement a minimum standard of five days of employer-paid sick leave every year.**
- **Now, employees in BC are able to take a sick day when they need it. This decision came after extensive and wide-ranging consultations.**
- **Paid sick leave applies to all employees covered by BC's Employment Standards Act (ESA), including temporary or casual employees.**
- **Paid sick leave is an important way we can support workers and help prevent the transmission of disease.**
- **We know that staff absences in the health workforce can have impacts on service delivery and that staffing resources are critical for providing the care that British Columbians deserve.**
- **That is why Our Health Human Resources Strategy, announced in fall 2022, has 70 concrete actions focused on training, recruitment, and retention of health care workers.**
- **These actions address staffing capacity issues throughout the health-care system and will help alleviate the burden on our health-care workers.**

CURRENT SITUATION

- From 2017 to 2021 sick time in the health sector has been steady from an average of 5.8% of productive hours in 2016 to 5.7% in 2021[1] . However, through the first 3 quarters of 2022, sick time has been significantly higher at 7.3% of productive hours.

[1] HSCIS Payroll data collected by HEABC

Table 1. Nursing and allied professionals, sick time as percentage of productive hours, 2019-2022Q3, payroll data



	Q1	Q2	Q3	Q4
2019	6.5%	5.4%	5.4%	6.2%
2020	6.8%	4.8%	5.2%	5.7%
2021	5.2%	5.1%	5.8%	6.9%
2022	7.6%	7.5%	6.9%	

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Employment Standards Act (5-day paid leave):

- Effective January 1, 2022, Section 49.1 of the *Employment Standards Act* (ESA) was amended to include a general entitlement to paid sick leave for personal illness or injury after 90 consecutive days of employment.
  - On November 24, 2021, Government passed regulation designating the entitlement at five days of paid sick leave in each employment year.
  - Effective January 1, 2022, employees covered by collective agreements with guaranteed sick leave that "meets or exceeds" 5 days receive sick leave in accordance with their collective agreement, not the ESA. Based on this test, ESA paid sick leave was not applied to casual employees.
  - Effective March 31, 2022, the ESA was further amended to remove the "meet or exceed" test. This means that the five days of sick leave must be granted to all employees, including casual employees.
  - Casual employee entitlements took effect March 31, 2022 and are not retroactive.
  - In addition, this ESA amendment included a change from the annual entitlement applying to the individual's employment year calculated from their date of hire to the calendar year.
- As of March 31, 2022:
  - All employees, including casual, are eligible for paid sick leave after 90 continuous days of employment.
  - Section 49.1(3) indicates that employees must be paid no less than an average day of pay for each sick day.
    - Average Day = (amount paid in previous 30 days excluding overtime) divided by (number of days worked in the last 30 days)
- Public health sector employees are eligible to benefit from these new changes, and employers have implemented the paid sick leave.

Reporting:

- Health Authorities collect absenteeism data through a variety of different sources.
  - Island and Northern Health Authorities use scheduling systems whereas Vancouver Coastal, Fraser Health, Interior Health, Providence Health, and PHSA use a 24-7 phone-in employee absence reporting line (EARL).

- Neither of these sources is able to fully capture the duration of a leave but payroll systems include a roughly 3-week lag (2 weeks to the end of the pay period and 1 week for data validation and cleanup).

LAST UPDATED

The content of this fact sheet is current as of February 6, 2023, as per Evan Howatson, Executive Director, Labour and Agreements Branch.

APPROVALS

2023 02 12 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 02 26 - Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

International Medical Graduate-BC Return of Service Program

Topic: To ensure there are a sufficient number and appropriate mix of physicians now and in the future, the Province agrees to fund a designated number of postgraduate medical education (PGME) positions for International Medical Graduates (IMGs) in exchange for a practice commitment in a health authority-identified community in BC.

Key Messaging and Recommended Response:

- **Training more health care workers, including doctors, to deliver services for British Columbians is one of our top priorities.**
- **That is why we fund programs like the Postgraduate Medical Education (PGME) International Medical Graduate (IMG) Program.**
- **PGME-IMG provides international medical graduates with an opportunity to train and qualify as a practicing physician in BC. After completing residency, family medicine participants complete a two-year return of service (ROS), and specialist participants complete a three-year ROS in an identified community of need, often in rural or remote areas.**
- **We fund UBC residency positions that are protected for international medical graduates:**
    - **The IMG-BC program at UBC has expanded substantially from six annual entry positions in 2003 to 58 today.**
    - **These 58 positions are specially protected for IMGs and include 52 in family medicine, an area of great need for British Columbians.**
    - **PGME-IMG residency positions are funded in family medicine, internal medicine, pediatrics, and psychiatry.**
    - **As of January 2023, 427 family physicians and 66 specialists have been placed in 91 communities in BC.**
- **Since 2006, the Province of BC has funded the residency positions of 703 participants.**
- **Since 2017, the Province of BC has funded the residency positions of 311 family medicine participants and 35 specialist residents.**

- **This program directly addresses physician staffing issues throughout the health-care system and will help ensure that people living in BC have access to the care they need.**

CURRENT SITUATION

- 56 IMGs (53 Family Medicine; 3 Specialty) started their return of service (ROS) in 2021 and 65 IMGs (55 Family Medicine and 10 Specialty) in 2022.[1]
- As of January 4, 2023, 427 family physicians and 66 specialists have been placed in 91 communities.[2]

FINANCIAL IMPLICATIONS

- In 2021/22, the Ministry of Health allocated a total of over $163M to the University of BC (UBC) Faculty of Medicine to support PGME residency training, up from $135M in 2017.
- In 2021/22, the Ministry provided over $16M to UBC Faculty of Medicine to support IMGs through their PGME training in Family Medicine, Psychiatry, General Pediatrics, and Internal Medicine.

KEY BACKGROUND

- The Province of BC's physician Return of Service (ROS) programs are patient-focused initiatives. These programs support equitable access to government-funded health services for residents across BC.
- IMGs are a diverse group of Canadian citizens or permanent residents who complete their medical education at medical schools outside of Canada or the United States as listed in the World Directory of Medical Schools.
- The Province funds a designated number of training positions for IMGs and in exchange the participants complete a ROS. To return service, participants in these programs provide government-funded health services in a designated area of critical need in BC Participants sign a contract with the Province that details the ROS commitment.

<u>Medical Education and Residency</u>

- Medical education varies among IMGs due to the different evaluation and credentialing processes at international schools. As a result, IMGs must pass a series of examinations that test knowledge, skills, and aptitude to assess their readiness for entrance into a Canadian residency program including the:
    - Medical Council of Canada's (MCC) Qualifying Examination Part 1 (MCCQE1)[3] – a summative examination assessing critical medical knowledge and clinical decision-making ability.
    - National Assessment Collaboration (NAC) – an objective structured clinical exam which is a series of mock clinical situations with standardized patients in designated stations.[4]
- IMGs applying to PGME positions in BC through the Canadian Resident Matching Service (CaRMS) participate in UBC's one-day Clinical Assessment Program. The program assesses candidates' clinical experience, potential for success in residency and suitability for working in BC.[5]
- To attain an IMG residency position through CaRMS, IMGs must also meet the basic eligibility criteria and have no prior PGME training in Canada or the United States. This does not preclude individuals with PGME training from non-approved jurisdictions from applying (approved jurisdictions are determined by the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada and have been assessed against the national college's standards).
- IMGs compete for entry-level (1st year) dedicated IMG residency positions in the first iteration of CaRMS and for unfilled IMG and Canadian medical graduate positions in the second iteration of the match.

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[1] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health. IMG-BC Community Placements. Data as of January 4, 2023.
[2] Ibid.
[3] MCC (2023). MCCQE1. https://mcc.ca/examinations/mccqe-part-i/ Last accessed January 30, 2023.
[4] MCC (2023). NAC https://mcc.ca/examinations/nac-overview/ Last accessed January 30, 2023.
[5] UBC Faculty of Medicine. (2021). Clinical Assessment Program. https://imgbc.med.ubc.ca/clinical-assessment/ Last accessed January 30, 2023.

- In 2022, 1,322 IMGs applied for 331 IMG-dedicated residency positions through CaRMS.[6]

Reducing Barriers to PGME

- IMG entry-level PGME positions at UBC have increased from 6 in 2003 to 58 (52 Family Medicine and 6 general specialty) by 2019, including 40 new positions since 2011[7]. Priority is given to Family Medicine, Internal Medicine, Pediatrics and Psychiatry.
- IMGs who obtain a residency position at UBC take part in an orientation on the Canadian medical system and are introduced to tools and resources to help them succeed in residency.
- Students from international medical schools can apply to UBC's Visiting Electives Program in their final year of study if their school has a "Canada" designation on the World Directory of Medical Schools. Clinical electives provide IMGs with an opportunity to gain practical experience in BC's heath care system and demonstrate their clinical skills.[8]

LAST UPDATED

The content of this fact sheet is current as of February 16, 2023 as confirmed by Kevin Brown, Health Sector Workforce and Beneficiary Services Division

APPROVALS

2023 02 23 – Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[6] CaRMS (2022). R-1 Data and Reports 2022 R-1 Match Reports Tables 1 and 14. http://www.carms.ca/data-reports/r1-data-reports/ . Last accessed January 30, 2023.

[7] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health. (2021). Master Tracker. Data as of September 16, 2022.

[8] AFMC Student Portal (2022).https://afmcstudentportal.ca/. Last accessed January 30, 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

Internationally Educated Allied Health Professional Bursary Program

Topic: Health authorities (HAs) across BC are experiencing critical shortages of health care workers which is impacting service delivery. Internationally Educated Allied Health Professionals (IEAHPs) are needed to complement the domestically trained workforce to meet Ministry strategic priorities and patient and population health outcomes.

Key Messaging and Recommended Response:

- **There has been an unprecedented demand on the health-care system here in BC, as well as nationally and internationally. The health-care worker shortage is an issue facing health-care systems around the world.**
- **Here in BC we are taking actions to recruit, train and retain allied health professionals. This includes adding a total of 270 new ongoing allied health seats to BC's public post-secondary institutions.**
- **We are also prioritizing retention and recruitment, which we are doing by removing roadblocks for allied health professionals trained in other countries who want to work in BC.**
- **We've heard from internationally educated allied health professionals (IEAHP) about the challenges they face entering the workforce and we are working to address those challenges.**
- **Action 37 in our Health and Human Resources (HHR) strategy includes the implementation of an IEAHP assessment support program to facilitate access to public-sector careers in allied health. In July 2022, we announced $4.5 million in bursaries that support this strategy.**
- **This program is being developed in partnership with, and will be administered by, Health Match BC (HMBC). It will include bursaries and client-focused navigation services to cover costs associated with professional registration and certification of IEAHPs.**
- **Internationally educated physiotherapists (IEPTs) have been identified as the first occupation to prioritize for the bursary program and is scheduled to be launched in Spring 2023.**

LEGISLATIVE SESSION – ESTIMATES NOTE

- **Bursary programs for Internationally educated medical laboratory technologists (IEMLTs) and internationally educated occupational therapists (IEOTs) will follow shortly after.**
- **Ultimately, these actions mean more allied health-care professionals to relieve pressures and reduce staff shortages in our health-care system.**

CURRENT SITUATION

- On July 19, 2022, the Ministry of Health announced education, recruitment, and retention initiatives to help meet the increasing demand for allied health care workers in BC.[1] This included $4.5M in bursaries to support priority IEAHPs.
- This program is being developed in partnership with, and will be administered by, Health Match BC (HMBC) and will be designed to recruit IEAHPs into the public sector.
- On September 29, 2022, The Ministry released *StrongerBC: B.C.'s Health Human Resources Strategy* (the Strategy.) The Strategy includes, under Action #37, the implementation of an IEAHP assessment support program to facilitate access to public-sector careers in allied health. This program will include bursaries and client-focused navigation services to cover costs associated with professional registration and certification of IEAHPs.
- Internationally educated physiotherapists (IEPTs) have been identified as the first occupation to prioritize for the bursary program, followed by internationally educated medical laboratory technologists (IEMLTs) and internationally educated occupational therapists (IEOTs.) Additional occupations will be added in a phased approach over the next few years.
- The IEPT bursary program is scheduled to be launched in Spring 2023, with the IEMLT and IEOT bursary to follow shortly after.

FINANCIAL IMPLICATIONS

The Minister's announcement on July 19, 2022, included $4.5 million in bursaries to support IEAHPs from high priority occupations that want to work in BC. These funds are currently being held by HMBC.

KEY BACKGROUND

- Each allied health occupation has its own specific qualifying process, including credential evaluation, bridging or refresher courses, and often followed by certification or licensing examinations. Additionally, IEAHPs who were educated in a language other than English will need to complete an English language assessment.
- Registration and certification pathways for IEAHPs can cost thousands of dollars and prevent IEAHPs from seeking a credential assessment to practice in BC; bursary funds will help reduce these financial barriers and allow individuals to practice in BC.
- A high-level framework is being developed to assist in the implementation of bursaries for additional professions. This framework is guided by lessons learned from the development of the IEPT, IEMLT, and IEOT bursaries as well as a review of the Nursing Community Assessment Service (NCAS) and Practice Readiness Assessment BC (PRA-BC).
- To protect the government's investment, recipients will be required to complete a return of service (ROS), committing to working within BC's public health system for a specified minimum length of time.

[1] BC Ministry of Health. (2022, July 19). *British Columbia trains, recruits more allied health professionals*. [Press release]. Retrieved from https://news.gov.bc.ca/releases/2022HLTH0047-001138

- In alignment with the recently launched internationally educated nurse (IEN) bursary[2], HMBC will support this program by providing an enhanced recruitment system, allied health navigators, and bursary disbursement.
- To begin the process of developing the bursary program, the Allied Health Policy Secretariat (AHPS) reviewed the full range of allied health occupations to prioritize and selected a subset of occupations that could benefit from financial support.
    - Criteria for this selection process included: occupations aligned with the Ministry's strategic priorities with known high vacancy rates; occupations identified by HAs as priority occupations; occupations with existing credentials assessment and formal bridging or exam preparation processes; occupations where there are substantial credentials assessment costs.
- The IEAHP bursary program is expected to increase the supply of high-priority allied health professionals in the public healthcare system.
- IEAHPs are currently supported with the credentialing, job finding, and immigration process by several other BC government programs:
    - HMBC currently provides job search and immigration support to internationally educated physiotherapists, occupational therapists, clinical pharmacists, medical laboratory technologists, diagnostic medical sonographers, and medical radiation technologists.[3]
    - Through the Career Paths for Skilled Immigrants program, IEAHPs can access financial support for language and skills upgrading, career planning and coaching, and other supports that assist with pathways to BC employment.[4]
    - IEAHPs who meet the applicable requirements for licensure and/or certification, and have a formal job offer in BC may be eligible for immigration support with the Provincial Nominee Program (health care occupation category).[5]

LAST UPDATED

The content of this fact sheet is current as of January 31, 2023, as confirmed by Lorrie Cramb, A/Executive Director – Allied Health Policy Secretariat.

APPROVALS

2023 02 06 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 02 20 - Rob Byers, Finance and Corporate Services Division

[2] BC Ministry of Health. (2022, April 19). Supporting international nurses into BC's health system. [Press release]. Retrieved from https://news.gov.bc.ca/26635
[3] Health Match BC. Allied Health. https://www.healthmatchbc.org/Health-Professionals/Allied-Health Accessed 30 January 2023
[4] Province of BC. Career Paths for Skilled Immigrants. https://www.welcomebc.ca/Work-in-B-C/Career-Paths-for-Skilled-Immigrants. Accessed 30 January 2023
[5] Province of BC. About the Provincial Nominee Program. https://www.welcomebc.ca/Immigrate-to-B-C/About-The-BC-PNP. Accessed 30 January 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

Internationally Educated Nurse and Nurse Re-entry Support Program

Topic: Reducing barriers for Internationally Educated Nurses' (IENs) entry into BC's health workforce, will help meet growing labour demand. Reducing financial barriers for both IENs and nurses seeking to return to practice supports the Ministry of Health's commitment to implement Action 36 of the Provincial Health Human Resources Strategy[1], and the 2022 Ministry's Mandate Letter.[2]

Key Messaging and Recommended Response:

- **Internationally trained nurses faced roadblocks to working in this province–we have taken actions to remove these blocks.**
- **We worked closely with the BC College of Nurses and Midwives to provide funding to develop a more efficient process that simultaneously assesses IENs for the HCA, LPN, & RN designations.**
    - **This new process helps determine where IENs best fit in BC's health workforce and allows them to start work sooner as an HCA or LPN while upgrading their training to work as a Registered Nurse.**
- **On January 9, we announced more supports for IEN's wanting to work in BC's health care system including directly covering the $3700 application and assessment fee for IEN's and a new pathway through BCCNM and NCAS that will reduce registration wait time down from 3 years to 4-9 months.**
- **Government has also invested in financial supports to help nurses that want to return to practice after a period of absence.**
    - **This includes covering the $300 BCCNM application fee, over $4,000 in new supports to cover assessments and eligible travel costs, and up to $10,000 in bursaries for any additional education required for nurses returning to practice.**
- **Ultimately, these actions mean more nurses to relieve pressures and reduce staff shortages in our hospitals.**

[1] BC Government (2022). New health workforce strategy improves access to health care, puts people first. News Release, September 29, 2022. https://news.gov.bc.ca/27538 Accessed on February 10, 2023.
[2] Ministerial mandate Letter from the Honourable David Eby to the Honourable Adrien Dix, December 7, 2022. https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/hlth_-_dix.pdf Accessed February 10, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- A $9 million bursary program to help offset IENs' costs for assessments, applications, and educational bridging costs required to practice as a health care worker (RN, LPN or HCA) was announced in a Provincial News Release on April 19, 2022 (https://news.gov.bc.ca/26635). Eligibility criteria apply and bursaries are subject to IENs signing a 1-year full time Return of Service (ROS) agreement.
- An additional $3 million was provided to hire nurse navigators with Health Match BC (HMBC) and to fund a simplified Nursing Community Assessment Service (NCAS) 'Triple-Track' competency assessment process.
- Since the announcement, 9,000 IENs have expressed an interest in working in BC and may contemplate starting the registration process and 2,648 more have self-reported that they are actively working through the various stages of the registration pathway. Over 90% of the 2022 applications received by BC College of Nurses and Midwives (BCCNM) were received after the announcement.
- In September 2022, the Ministry provided BCCNM with an additional $1.3 million to support the development of a streamlined IEN application and registration pathway which will reduce the time it takes from initial application to registration decision to 4-9 months from approximately 1-3 years. From there some nurses may require additional training, will need to pass one of the national nursing exams and/or then obtain a license or register as an HCA with the BC Care Aide and Community Health Worker Registry.
- The new IEN pathway was announced on January 9, 2023, through a Provincial News Release (https://news.gov.bc.ca/28054) and launched on January 31, 2023.[3] The new pathway also includes a new process waiving BCCNM and NCAS application fees so IENs no longer have to pay these fees up front and added four more agencies who can provide IEN credential reports.
- The money for IEN bursaries has also been extended to provide supports to nurses who previously held a practising nursing license (and consolidated their practice) in Canada and want to return to practice.

Advice/Recommentations; Cabinet Confidences

FINANCIAL IMPLICATIONS

- In 2020/21, $1.215 million was provided to BCCNM/NCAS for the 'Triple-Track' assessment process.
- In April 2022, the Ministry provided HMBC with the remainder of over $12 million to support the development and hiring of nurse navigators and for IEN application, assessment and educational bursaries.
- In September 2022, $1.3 million was approved for BCCNM to fund the pilot IEN registration pathway.

KEY BACKGROUND

- Registering as a nurse or HCA in BC as an IEN is a complicated, lengthy, and expensive process. It involves testing, assessments, and the submission of a large amount of documentation.
- The IEN application process costs approximately $6,000 if a competency assessment is required. This excludes language test costs (if required)[4], document translation fees, travel, licence fees and national exam fees. IENs who require remedial education also have to pay an additional $500 to $10,000.
- Historically, it has taken IENs approximately 2-6 years to obtain nursing registration in BC.[5] [6]
- IEN applicants must first obtain a credential assessment report, when applying to any province or territory. Until recently the only authorized agency was the National Nursing Assessment Service (NNAS). Historically, a BCCNM review, an NCAS assessment, and potentially additional education followed.
- A business case to reduce IEN barriers to entry into the healthcare system was developed in 2021, in collaboration with health partners, which led to the following:

[3] BCCNM (2022). Briefing Note – Funding Request for Internationally Educated Nurses (IEN) Pathway Pilot Initiative. Cynthia Johansen, Registrar & CEO. September 14, 2022.
[4] BCCNM (2021). English proficiency. https://www.bccnm.ca/RN/applications_registration/Pages/English_proficiency.aspx. Accessed September 10, 2021.
[5] NNAS (2020). Frequently Asked Questions, The Advisory Report – How long does it take to get an Advisory Report and how long does the application process take? https://www.nnas.ca/faqs/ Accessed on October 8, 2020.
[6] BCCNM (2021). Applying to BCCNM. https://www.bccnm.ca/RN/applications_registration/how_to_apply/InternationalEN/Pages/Applying.aspx. Accessed on September 10, 2021.

- Financial support from the Ministry to BCCNM/NCAS to develop a single assessment intake and fee for IENs seeking multiple registrations (i.e., RN, LPN and/or HCA – known as 'Triple Track'), which was launched in May 2022.
- A new bursary program (https://news.gov.bc.ca/26635) to cover IEN applicant/assessment costs, including eligible additional education when required. Additional funding was also allocated for navigators to help guide IENs through the registration process.
- BCCNM's re-affirmation of accepting alternative means to demonstrate English language competency through other forms of evidence such as demonstrating experience working in an English-speaking healthcare setting or where education was in English.[7] [8]
- A new IEN registration pathway, with NCAS expanding their role as the single access and payment point for the BC IEN application process. This pathway was launched on January 31, 2023.
- Shifting the credential assessment component to have NCAS focus on authenticating the applicant, their documentation and their program of study rather than requiring a course-by-course review of an IENs education as was previously required through NNAS. The process also resulted in an expanded list of organizations approved to provide credential reports in addition to NNAS. The acceptance of new organizations' reports reduces effort and cost, allowing credential assessments that many nurses already use as part of the Canadian Immigration process.[9] [10]

- BC Nurses (and Canadian nurses who consolidated their practice in Canada) that have not clinically practiced for greater than five years can either take an unpaid Supervised Practice Experience (SPE)[11] or an NCAS assessment prior to being able to reinstate their practice license (return to practice). Depending on NCAS results, these nurses may require additional education. The January 9, 2023, extended the IEN bursaries to provide the same supports to eligible Return to Practice nurses.

LAST UPDATED

The content of this fact sheet is current as of February 27, 2023, as confirmed by Zachary Matieschyn.

APPROVALS

2023 02 28 - Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[7] BCCNM (2021). Language proficiency assessment for international applicants transitions to BCCNM. https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=276 . Accessed on September 10, 2021.
[8] BCCNM (2022). IEN Pathway Pilot: Provincial Nurse and Allied Health Advisors Council (PNAHC). Presentation by Cynthia Johansen, CEO & Registrar, Sara Telfer, Executive Director & Deputy Registrar and Rita Parikh, Executive Director, NCAS. September 8, 2022 (Slide 7).
[9] BCCNM (2022). Briefing Note – Funding Request for Internationally Educated Nurses (IEN) Pathway Pilot Initiative. Cynthia Johansen, Registrar & CEO. September 14, 2022.
[10] Approved credential assessment agencies include: NNAS, The Canadian branch of World Education Service (WES), Comparative Education Service (CES), International Credential Assessment Service (ICAS) International Credential Evaluation Service (ICES).
[11] SPEs must be approved by a health employer and accepted by BCCNM.

LEGISLATIVE SESSION – ESTIMATES NOTE

IVF Coverage

Topic: Coverage of in vitro fertilization under the Medical Services Plan.

Key Messaging and Recommended Response:

- **We understand that many British Columbians dream of starting or expanding their families, and it can be devastating when they struggle to do so.**
- **The Medical Services Plan (MSP) covers costs related to infertility assessments and investigations,which includes detailed gynecological investigations to determine the cause of infertility, lab tests to measure hormones related to ovulation, and seminal examination to determine the presence or absence of sperm.**
- **MSP also covers artificial insemination. In 2020/2021, MSP covered more than 3,600 procedures.**
- **While MSP doesn't cover IVF, this is not a comment on the value of the treatment, but rather a reflection of the availability of public funding for health care.**
- **As such, we will continue to cover many costs related to infertility assessments, investigations and artificial insemination, while monitoring developments in IVF.**
- **Our focus is to ensure that British Columbians have access to effective, medically necessary procedures while keeping health care costs sustainable.**

CURRENT SITUATION

- Medical Services Plan (MSP) coverage related to infertility is limited to infertility investigations, such as detailed gynaecological investigations to determine the cause of female infertility, lab tests to measure hormones related to ovulation, seminal examination to determine the presence or absence of sperm in the case of suspected male infertility, and artificial insemination performed in a doctor's office.
- In vitro fertilization (IVF) is not covered by MSP. This is not a comment on the value of IVF, but rather reflects the limits of available public funding.
- While the Ministry of Health is aware that some provinces now support IVF treatments through either direct funding or tax credits, the decision of these jurisdictions does not alter the current position for the Ministry.
- At this time, the Ministry is committed to maintaining its current coverage of infertility investigations and initial infertility treatments and will continue to monitor developments in IVF.

FINANCIAL IMPLICATIONS

N/A

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- MSP is governed by the *Medicare Protection Act and Regulations*. This legislation stipulates that only those services considered medically necessary may be a benefit of MSP to eligible and enrolled BC residents.
- Physician services covered by MSP are listed in the Medical Services Commission (MSC) Payment Schedule on the advice of the Doctors of BC (DoBC).
- Additions, deletions and other changes to the MSC Payment Schedule are made in consultation with the DoBC and in accordance with the Physician Master Agreement.
- Physicians who wish to make modifications to the MSC Payment Schedule can submit their proposals to the DoBC Tariff Committee through the appropriate medical specialty section.
- The Ministry and the DoBC have agreed to consult with each other prior to submitting a recommendation to the MSC.
- If both parties agree to a revision, the MSC will adopt the recommendation as part of the MSC Payment Schedule if the service is medically necessary and consistent with the requirements of the *Medicare Protection Act and Regulations*.
- To date, no section has not brought forward an application for coverage of IVF.

LAST UPDATED

The content of this fact sheet is current as of March 5, 2023 as confirmed by Marie Ty, ED, Compensation Policy and Programs Branch.

APPROVALS

2023 03 09 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Laboratory Health Human Resources

Topic: Addressing high vacancy rates, recruitment, and retention of Medical Laboratory Assistants and Medical Laboratory Technologists across the province to meet health system demands.

- **Our government recognizes the critical roles that Medical Laboratory Assistants and Medical Laboratory Technologists (MLTs) play in the health-care system, particularly in the diagnosis, treatment, monitoring, and prevention of diseases.**
- **We acknowledge the significant challenges facing both Health Authorities and publicly funded labs in meeting the staffing requirements for Medical Laboratory Assistants and MLTs, which have been exacerbated by the COVID-19 pandemic.**
- **To address this issue, we're working closely with the Ministry of Post-Secondary Education and Future Skills, Health Authorities, and representatives from LifeLabs and Valley Medical Laboratories, through a Joint Medical Laboratory Assistants and Technologist Working Group established in Winter 2022.**
- **The government has taken several actions, in alignment with the StrongerBC: *BCs Health Human Resources Strategy*, to optimize the health system, expand training, and further improve recruitment and retention of qualified MLAs and MLTs.**
- **These actions include developing bursary programs, expanding seat capacities, and mapping roles/tasks performed by lab professionals to optimize workloads and care models.**
- **We're committed to addressing the challenges facing Medical Laboratory Assistants and Technologist staffing to ensure that ourhealth-care system has the necessary capacity to provide quality care to British Columbians.**

CURRENT SITUATION

- The Ministry of Health is working closely with the Ministry of Post-Secondary Education and Future Skills (PSFS), Provincial Laboratory Medicine Services at the Provincial Health Services Authority (PHSA), laboratory managers/directors from each regional HA, and a representative each from LL and VML to find solutions to address the recruitment and retention of laboratory personnel at a Joint MLA/MLT Working Group, established in Winter 2022.

- Challenges with MLA and MLT staffing had been present prior to the global pandemic, but because of increased pressures associated with COVID-19 testing, the situation worsened.
- PSFS reports challenges with MLA student recruitment, partially linked to academic prerequisites. Many eligible students are drawn to other educational programs that will allow them to make higher wages upon graduation. As a result, MLA programs are often undersubscribed resulting in low graduate numbers.
- HAs reported the following challenges:
- MLAs
- MLAs perform important pre-analytical functions such as phlebotomy (venipunture), sample collection, preparing chemical reagents, and other clerical duties.
- Many MLAs have resigned from permanent positions to work in non-direct patient care areas or take casual status due to burn out.
- Shortages of MLAs, especially in the Interior and on Vancouver Island, have resulted in temporary closures of some labs.
- MLTs
- MLTs perform routine and complex tests, and laboratory investigations for the diagnosis, treatment, and prevention of disease.
- The increased workload on MLTs due to the demands of COVID-19 testing has led to greater shortages of staff for regular patient services.
- The Ministry, working with PSFS, PHSA and BC Institute of Technology (BCIT) developed a standardized curriculum (online modules) for upgrading molecular testing knowledge and skills in support of MLTs performing COVIC-19 testing.
- The BC Centre for Disease Control has a variance from the Diagnostic Accreditation Program (DAP) to hire graduates of Bachelor of Science in Microbiology (BScs) who can perform molecular testing. Regional HAs are also working with DAP for local variances to meet operational needs. The variance was extended to December 2023 to address potential COVID-19 waves in the future.

FINANCIAL IMPLICATIONS

- An investment of $65.8 million over three years, beginning with $14.1 million in 2021/22, to expand health education programs across the province is underway.
- On July 19, 2022: the Ministry of Health announced $1.5M in funding to support 36 Facilities Bargaining Association employees to become MLAs to help support critical staffing shortages; $3M in professional development funding to the Health Science Professional Bargaining Association to support the training and upgrading of health-science professional development in occupations such as MLTs; and $4.5M in bursaries for internationally educated high-priority allied health professionals that want to work in BC.[1]
    - The Ministry is developing a bursary program for internationally educated MLTs (IEMLTs), that will provide financial and navigational assistance by Health Match BC to support IEMLTs in the journey of becoming certified with Canadian Society of Medical Laboratory Science (CSMLS) so they can work as MLTs in BC.

KEY BACKGROUND

On September 29, 2022, the Ministry released StrongerBC: *B.C's Health Human Resources Strategy* (the Strategy) to optimize the health system, expand training, and further improve recruitment and retention.[2] To date, the Ministry has taken the following actions in alignment with the Strategy:

MLAs

The Joint MLA/MLT Working Group continues to inform and support provincial training, recruitment, and retention of qualified MLAs. Key activities include:

- Estalishing the MLA Bursary Program (July 2022 announcement) to train 36 FBA members to become MLAs

[1] BC trains, recruits more allied health professionals. Retrieved September 15, 2022 at British Columbia trains, recruits more allied health professionals | BC Gov News

[2] Stronger BC: BC's Health Human Resources Strategy: https://news.gov.bc.ca/files/BCHealthHumanResourcesStrategy-Sept2022.pdf

- Mapping roles/tasks performed by lab professionals to optimize workloads and care models
- Increasing capacity of training opportunities by adding 24 seats to Vancouver Community College MLA program for the September 2022 intake period
- Increasing pre-practicum clinical workshop capacity by 28 spots for students taking the online MLA program at Thompson Rivers University
- Conducting a jurisdictional review to identify innovative ways to deliver lab services, optimize the laboratory workforce, and identifying current and emerging technologies

MLTs

- In September 2022, BCIT implemented changes to their MLT program to improve student retention, satisfaction, and practice-readiness. This work is expected to increase the number of BC MLT graduates.
- Seat expansions have been implemented at BCIT (an additional 16 students September 2022) and the College of New Caledonia (CNC) (an additional 12 students in January 2023).
- Developing a bursary program for IEMLTs to become certified to work in BC.

Education and Training

- The MLA program is a certificate-level program that is 6-10 months in length. There are currently 9 post-secondary institutions in BC that are approved by BC Society of Laboratory Science (BCSLS) to offer this program, 3 of which are public.[3] Programs vary between part-time, self-paced, and full-time depending on the institution; however, an in-person practicum is mandatory. Certification with BCSLS is not legally required to practice as an MLA, though most employers require it.
- The MLT program is a diploma-level program that is 2.5 years in length, offered at BCIT and the CNC. BCIT requires a 35-week clinical practicum, and CNC requires a 39-week clinical practicum. BCIT has an 96-seat student cohort annually, and CNC has roughly a 36-seat cohort annually. Employers require that MLT graduates pass the certification examination with the CSMLS in order to practice.
- Advice/Recommentations; Government Financial Information

LAST UPDATED

The content of this fact sheet is current as of April 14, 2023, as confirmed by Vanessa Manuel, Director, Allied Health Policy Secretariat on behalf of Lorrie Cramb, A/Executive Director, Allied Health Policy Secretariat.

APPROVALS

2023 04 17 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION - FACT SHEET

Longitudinal Family Physician Payment Model

Topic: Overview of the new Longitudinal Family Physician (LFP) Payment Model.

Key Messaging and Recommended Response:

- **Over the past years, many family physicians have told us that the historical 'fee for service' model for primary care is no longer working, either for them or for their patients.**
- **That is why we worked with the Doctors of BC to create the new "Longitudinal Family Physician Payment Model" (LFP)**
- **The new model includes payments for:**
  - **patient visits;**
  - **time spent on direct care;**
  - **indirect care and clinical administration;**
  - **and the size and complexity of a family physician's patient panel.**
- **In a departure from the fee-for-service, the LFP model fairly compensates family physicians for time spent managing and coordinating their patient care, which we know may involve much more than the initial visit with a patient.**
- **A full time family physician practicing under the new LFP model is expected to earn approximately $425,000 in 2023/24, up from $385,000 in 2022 due to negotiated increases in the Physician Master Agreement (PMA)The various elements of the model are weighted proportionally and presently have the following values:**
  - **Time = $130 hour (54.9% of total compensation)**
  - **Encounters/visits = $25/visit (31.4% of total compensation)**
  - **Panel Size and complexity = Year 1 - $54,100 (13.7% of total compensation)**
- **The overall rate will be further adjusted to approx. $409,398 per year as 2023 PMA increases are added in April 2023.**
- **The Longitudinal Family Practice Model in BC is seeing remarkable success, with 2,794 physicians enrolled today.**

- **Over 50% of whom were longitudinal family docs last year.**
- **Moreover, over 300 physicians who were not in the system last year have enrolled.**

CURRENT SITUATION

- Almost one million British Columbians do not have a family physician. To address this issue, the Ministry of Health in partnership with Doctors of BC (DOBC) and BC Family Doctors (BCFD) developed the Longitudinal Family Physician Payment model.
- The LFP Payment Model currently covers office-based services and has three payment components: time, patient interactions, and a panel payment tied to the number and complexity of attached patients. Total compensation is approximately 30% higher than fee-for-service (FFS) for a similar basket of services.
- To be eligible, a longitudinal family physicians must meet the eligibility criteria, including having a panel of at least 250 patients and providing at least 70% of their services to these patients.
- Registration for the LFP Payment Model opened on January 20, 2023, and physicians began billing on February 1, 2023.
- In early March 2023, the eligibility criteria were expanded to include locums who substitute for family physicians participating in the LFP Payment Model, as well as physicians with walk-in and specialized practices actively working to transition to a longitudinal practice and meet the eligibility criteria by March 31, 2024.
- As of April 18, 2023, 2,794 physicians had registered for the LFP Payment Model, 57.7% whom were longitudinal family physicians in BC last year. Of those who have registered:
  - 94 had not previously identified themselves as longitudal physicians
  - 154 are new to practice or MSP
  - 165 are locums for physicians registered under the LFP Payment Model
- Physicians have expressed to DOBC that they are supportive of the new LFP Payment Model.
- The introduction of the LFP Payment Model has destabilized care and existing compensation arrangements in some communities and areas of family practice not currently covered by the model. The Ministry and DOBC are working to address these issues as part of the next phase, which will include rural practice, team-based care, virtul care, emergency services, maternity care, palliative care, and facility-based services. In the interim, mitigation strategies are being explored and implemented.
- The LFP Payment Model provides another compensation option for longitudinal family physicians. Physicians can remain on their existing compensation modality or transition to the LFP Payment Model. Some select compensation modalities will be remain available to clinics who are currently on the model, including recruiting additional physicians, but will not be expanded to other clinics going forward, e.g., Group Contract for Practicing Full-Service Family Physicians introduced in fall 2020.

FINANCIAL IMPLICATIONS

- The LFP Payment Model is estimated to be approximately a 30% increase from FFS. The financial implication will depend on the number of physicians transitioning to the LFP Payment Model and new physicians establishing family practice. As of April 18, 2023, 57.7% of existing longitudinal family physicians have registered for LFP.
- Financial risks include higher than forecasted costs due to suboptimal pricing and/or higher than anticipated volumes, and challenges making appropriate adjustments due to limited service data.

KEY BACKGROUND

- The LFP Payment Model is expected to improve recruitment of and retention of family physicians and increase patient access and attachment.

LEGISLATIVE SESSION - FACT SHEET

- Under the LFP Payment Model, physicians bill for their time and each patient interaction, and receive quarterly payments based on the size and complexity of their patient panel.
- To be eligible, a family physician must have a known panel of at least 250 patients within four months of registering for the LFP payment model and maintain a 70/30 ratio of longitudinal/episodic care within their practice. They must also contribute to the rent, lease, or ownership costs, as well as operating costs of their LFP clinic(s).
- A physician who works 1680 hours, with a panel of 1250 patients of average complexity, and engages in 5000 patient interactions per year is expected to earn $425,000 under the LFP Payment Model, (up from $385k in 2022 due to negotiated PMA increases). This is estimated to be approximately 30% more than they would earn under FFS for the same basket of services.
- There are three time codes (direct patient care, indirect patient care, and clinical administrative) all valued at $130 per hour, and eight patient interaction codes ranging from $10 – 110 (Part V and Part VI). Panel payments will vary depending on panel size and complexity but are paid at approximately $53.52 per patient of average complexity.
- The methodology for the panel size and complexity payment is being developed collaboratively with DOBC and BCFD. In the interim, the methodology used by the Family Physician Services Committee to make annual panel payments to longitudinal family physicians will be used to calculate the quarterly payment.
- LFP physicans will receive their first panel payment on August 31, 2023. The payment will be pro-rated based on days enrolled in model for the first and second quarter of 2023.
- Physicians working to transition their walk-in or specialized practice to a longitudinal family practice are able to bill under the LFP model and have until March 31, 2024 to grow their patient panel and to meet the 70/30 ratio.
- A locum, working on behalf of an LFP host-physician is eligible to register as an LFP Locum and bill to the model. LFP Locums are exempt from meeting the 70/30 ratio, and are not expected to maintain a patient panel.
- The LFP Payment Model is subject to Plan-Do-Study-Act (PDSA) cycles with DOBC and BC Family Doctors.
- The Ministry of Health, Doctors of BC, and BCFD are working to adapt the LFP Payment Model to rural communities and team-based care, and roll it out to facility-based settings and other areas of family practice this year.

LAST UPDATED

The content of this fact sheet is current as of April 18, 2023, as confirmed by Sarah Riddell.

APPROVALS

2023 03 13 – Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 13 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2023 04 20 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Midwives Association of BC Negotiations

Topic: Ongoing negotiations with Midwives Association of BC (MABC) for renewal of the Midwifery Master Agreement.

Key Messaging and Recommended Response:

- **At this time, the Ministry of Health is currently engaged in negotiations with Midwives Association of BC. We know how important it is that any deal reached will reflect government's commitment to recruit, train, and retain midwives.**
- **Some of the actions we've taken that directly impact midwives include:**
  - **Midwifery seat expansion: the Province is adding 20 seats to UBC's Bachelor of Midwifery (BMw) program, bringing the total annual intake to 48:**
    - **12 seats are being added to the BMw program, bringing the total annual intake from 20 to 32. (4 seats were added in September 2022; 8 seats are being added in September 2023.)**
    - **8 seats were added to the Internationally Educated Midwifery Bridging Program, in January 2022, bringing the total annual intake from 8 to 16.**
  - **We've supported a new pathway at UBC for Registered Nurses (RNs) interested in becoming midwives. The UBC Advanced Placement Plan allows RN applicants to reduce the 143 credit BMw program by 27 credit hours.**
  - **The Ministry is working with the BC College of Nurses and Midwives, the College of Physicians and Surgeons, and other stakeholders to review existing privileging processes. This action aims to create a provincial approach to privileging that will ensure providers have flexibility to practice in hospitals across regional health authorities.**
  - **The Ministry is working with partners including First Nations Health Authority to explore ways to support Indigenous midwifery in areas such as reclamation of Indigenous birthing practices and Indigenous remote birthing.**

LEGISLATIVE SESSION – ESTIMATES NOTE

- **Prior to announcing the HHR Strategy, the Ministry of Health, in partnership with the Midwives Association of BC, established the Midwifery Advisory Committee to support midwives in optimizing midwifery practice and addressing priority policy issues including:**
  - **optimization of midwifery scope**
  - **midwifery integration into primary care networks**
  - **midwifery leadership roles in the health system, with an Indigenous lens woven throughout all policy work.**
- **We will continue looking for opportunities with our partners at the BC College of Nurses and Midwives to support health-care workers as they strive to provide exceptional patient care in the province.**

CURRENT SITUATION

- Negotiations for the 2022-2025 Midwifery Agreement began on April 2022 between the Ministry of Health and the Midwives Association of BC (MABC). These negotiations are ongoing.
- Other agreements in the health sector have been ratified under the Shared Recovery Mandate, which allows for the following increases to compensation:
  - Year 1 - a flat increase of $0.25/hour, plus 3.24%
  - Year 2 - 5.5% plus a potential cost-of-living adjustment to a maximum of 6.75%
  - Year 3 - 2% plus a potential cost-of-living adjustment to a maximum of 3%
- Negotiations for the 2019-2021 Master Agreement did not result in an agreement and the matter was referred to binding arbitration.
- The arbitration decision was released in December 2021 and the terms of the decision were implemented throughout the 2022 calendar year. In the absence of a negotiated Master Agreement that covers the mandate period of April 1, 2019 to March 31, 2022, the Ministry considers the terms of the 2014 Midwife Master Agreement that were not altered by the December 2021 Arbitration Decision or the 2020 negotiation proposals from MABC and the Ministry to remain in effect until there is a new, formal agreement.

FINANCIAL IMPLICATIONS

The 2022 PSEC forecasted budget for midwifery payments is $53.0 million. It is anticipated that the Shared Recovery Mandate would be applied on top of this budget.

KEY BACKGROUND

- The 2014 Midwifery Master Agreement and the Midwifery Rural Services Subsidiary Agreement expired March 31, 2019.
- Negotiations for the 2019-2021 Midwifery Master Agreement began early March 2019 and concluded mid-October 2019 with a tentative agreement reached between the Ministry and MABC.
- MABC membership failed to ratify the tentative agreement and returned to negotiations in June 2020.
- The Ministry and MABC were unable to reach a tentative agreement, and the matter was referred to binding arbitration.
- An arbitration decision was provided on December 20, 2021, and the Ministry implemented the decisions of this arbitration throughout the 2022 calendar year.

LAST UPDATED

The content of this fact sheet is current as of February 2, 2023, as per Evan Howatson, Executive Director, Labour and Agreements Branch.

LEGISLATIVE SESSION – ESTIMATES NOTE

APPROVALS

2023 02 06 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 02 20 – Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Midwives

Topic: To support improved integration of midwives into the broader health system and better access to maternity care, the Ministry of Health (Ministry) is exploring more inclusive policy and compensation models.

Key Messaging and Recommended Response:

- **Midwives play an important role in the delivery of primary health care to pregnant people and their newborn babies from early pregnancy through labour and birth, and up to 12 weeks postpartum.**
- **Currently, there are 535 registered midwives in BC.**
- **In FY 2021/22, 11,819 or 27.1% of total live births in BC were assisted by midwives.**
- **Midwifery is an important part of providing culturally safe maternity care and supporting traditional birth practices for Indigenous people.**
- **In February 2023, the Province expanded the midwifery program at the University of BC by 20 seats, which is an increase of over 70%.**
- **The Province is working with the BC College of Nurses and Midwives and the Midwives Association of BC on policy to strengthen the role of midwives and better integrate them in the primary care and health system.**

CURRENT SITUATION

- In BC, registered midwives (RMs) are autonomous, regulated health professionals who offer primary health care to healthy pregnant people and their newborn babies, from early pregnancy through labour and birth, and up to 12 weeks postpartum.
- In FY 2021/22, in BC there were 11,819 live births assisted by midwives (27.1% of live births in the province) and in FY 2022/2023 (incomplete), 9,103 live births (26.6% of live births) have been assisted by midwives.[1]
- Midwives experience barriers to practicing to full scope, including challenges with hospital privileging, regulatory barriers, interprofessional misconceptions about midwifery care, and limited system integration.[2]
- As part of the provincial effort to address challenges facing maternity care, the Ministry is leading policy work to strengthen midwifery alignment into primary care networks and the health system.
- Indigenous midwifery is a key area of focus with demand increasing for resources and processes to enable Indigenous midwives to practice traditional Indigenous midwifery and reclaim Indigenous birth practices in community. The Ministry is collaborating with Perinatal Services BC and First Nations Health Authority to work towards a coordinated approach to support Indigenous midwifery and traditional birth practices.

[1]Email from Priority Projects and Joint Collaborative Committees, HSIAR to Nursing Policy Secretariat (NPS), February 15, 2023.
[2] Health Sector Workforce: Priority Health Sector Occupation Profiles, Health Workforce Planning and Implementation Branch, October 2021.

FINANCIAL IMPLICATIONS

In 2021/22, the midwifery services cost approximately $42.3 million[3] in fees, $2.4 million in the Midwives Association of BC (MABC) payments, and $0.6 million in midwifery contracts.The midwifery services budget for 2022/23 is approximately $46.4 million.

KEY BACKGROUND

- Midwifery is a designated profession under the *Health Professions Act*. The first midwives were registered to practice in BC on January 1, 1998.
- In BC, midwives offer primary health care to healthy pregnant women and their newborn babies, from early pregnancy through labour and birth, and up to 12 weeks postpartum.
- As a designated Most Responsible Provider in primary care throughout the antenatal period, midwives may be the first point of entry to maternity services and are fully responsible for clinical decisions and the management of patient care within their scope of practice.
- BC's midwifery model of practice is autonomous, community-based primary care, and incorporates the principles of continuity of care, informed choice, choice of birth setting, ethics and evidence-based practice.
- Midwives' care also includes physical examinations, screening and diagnostic tests, the assessment of risk and abnormal conditions, and the conduct of normal vaginal deliveries.[4]
- Midwifery services are a benefit under the BC Midwifery Program for eligible BC residents enrolled with the Medical Services Plan funded by the Ministry. MSP only covers services up to six weeks post partum.
- The BC College of Nurses and Midwives (BCCNM) is the regulatory body for the midwifery profession in BC Midwives practicing midwifery in BC must be registered with BCCNM.
- As of August 19, 2021, the Jurisprudence exam is no longer a registration requirement for RMs.[5]
- As of September 13, 2022, BCCNM had a total of 535 midwife registrants (350 practicing; 100 non-practicing, 79 student midwives, and 6 temporary emergency)).[6]
- To practice as a midwife in BC, the minimum educational requirement is a Bachelor in Midwifery (BMw).
- The University of BC (UBC) has offered a 4-year BMw program since September 2002.[7]
- UBC has offered an Internationally Educated Midwifery Bridging Program (IEMBP) since January 2016.[8] The IEMBP helps internationally trained midwives become registered for practice within BC.[9]
- Midwifery seat expansion: the Province is adding 20 seats to UBC's midwifery program, bringing the total annual intake to 48:
    - 12 seats are being added to the BMw program, bringing the total annual intake from 20 to 32. (Four seats added in September 2022; eight seats are being added in September 2023.)
    - 8 seats are being added to the IEMBP bringing the total annual intake from eight to 16. (These seats were added in January 2022). [10]
- UBC has developed an Advanced Placement Plan for Registered Nurses (RN) interested in becoming midwives which enables RN applicants to reduce the 143 credit BMw program by 27 credit hours.[11]
- In November 2020, the Ministry collaborated with MABC to secure free Personal Protective Equipment (PPE) for midwives and developed fee codes for COVID-19 testing and immunization for the pandemic response.
- MABC submitted a proposal for midwives to receive compensation for service delivery planning activities related to the COVID-19 pandemic response. The Ministry agreed to provide compensation to midwives to

[3] Email from Beneficiary and Diagnostic Services to NPS, September 21, 2022.
[4] Midwives Regulation, https://www.bclaws.gov.bc.ca/civix/document/id/lc/statreg/281_2008#section4.
[5] Ibid., https://www.bccnm.ca/BCCNM/Announcements/Pages/Announcement.aspx?AnnouncementID=283.
[6] Email communication from BCCNM to NPS, January 31, 2023.
[7] Email confirmation from the Ministry of Post-Secondary Education and Future Skills (PSFS) to NPS, February 1, 2023.
[8] Ibid.
[9] University of British Columbia, https://iembp.midwifery.ubc.ca/.
[10] Email communication from PSFS to NPS, January 31, 2023.
[11] University of British Columbia https://midwifery.ubc.ca/program/requirements/rn-advanced-placement-plan/.

a maximum of 35 hours in total for active planning performed between March 15, 2020, to March 31, 2021, at the rate of $122.28/hour provided certain criteria are met.[12]

- With the Provincial Health Services Authority and other partners, the Ministry is working to develop and implement a maternity services strategy that will include optimizing the use of midwives throughout BC.
- Beginning in 2020, 10 service contracts (2.0 FTEs per community) for midwives were implemented in 5 rural communities (formerly referred to as "1A contracts"). These were implemented to help stabilize service in those communities. Recently, the Ministry approved the addition of a third FTE in each of the 5 communities.

Arbitration/Negotiations

- Compensation to registered midwives is governed by a Midwifery Master Agreement between the Medical Services Commission, the Ministry, and the MABC.
- In 2019 and 2020 the Ministry and MABC attempted to negotiate an agreement for the 2019-2022 mandate period. They were unable to reach an agreement.
- During the spring/ summer of 2021, the Ministry and MABC participated in binding arbitration hearings. Submissions, witness testimony, and closing arguments were completed on July 20, 2021.
- On December 20, 2021, the arbitrator submitted a decision on the terms of the agreement under dispute.
- The Ministry has implemented the terms of the decision and proposed negotiation terms that were not under dispute.
- The Ministry began the 2022 round of negotiations with the MABC on April 4, 2022.

LAST UPDATED

The content of this fact sheet is current as of February 15, 2023, as confirmed by Zachary Matieschyn, Executive Director, Nursing Policy Secretariat Branch.

APPROVALS

2023 02 27 - Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 01 - Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03 21 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[12] Confirmed by Beneficiary and Diagnostic Services Branch, February 8, 2022.

LEGISLATIVE SESSION – ESTIMATES NOTE

MSP Charging for Bundled or Annual Services

Topic: Companies (and in some cases, clinics or independent practitioners) are offering bundled services to Medical Services Plan (MSP) beneficiaries for a fee (one time or annual) that may constitute extra billing.

Key Messaging and Recommended Response:

- **Access to universal health-care is a point of pride for Canadians from coast to coast.**
- **We are firm in our commitment that all people in BC have a right to a high-quality and comprehensive health-care system based on a patient's need— not their ability to pay.**
- **Any patients being asked to pay thousands of dollars in subscription fees to retain the services of their doctors is not only illegal— it's wrong.**
- **All companies and providers involved in providing MSP-insured services are expected to comply with the Medicare Protection Act and the Canada Health Act.**
- **When companies and medical professionals are found to violate the Medicare Protection Act, for example, by illegally bundling services, the Medical Services Commission will act as appropriate.**
- **In addition to companies already facing injunctions, The Commission is actively reviewing several other fee-based programs for potential contraventions of the Medicare Protection Act. Where appropriate, the Commission will make the public aware of additional enforcement measures against other entities.**
- **While we await the decision of the courts, we will continue our efforts in building and supporting BC's high-quality public health-care system.**

CURRENT SITUATION

- Many of these companies market these plans/programs as wraparound non-insured services (e.g., access to a dietician, regular physical exams, etc.). In some cases, the charges appear to be in relation to MSP benefits (e.g., 24-hour access to a physician).
- The Ministry of Health asked the Medical Services Commission (the Commission) to review and consider companies' business and service models, to confirm they are not providing priority access to MSP insured services, independent of acuity, because that also patient paid them a fee. To do so would not be consistent with the *Canada Health Act* (CHA) and/or the *Medicare Protection Act* (MPA).

- The Commission has contacted over a dozen entities that it is aware are offering bundled services and continues to contact new entities brought to its attention. These include corporations, bricks and mortar health care clinics, and independent practitioners.
- These communications have produced various results – from immediate steps to come into compliance with the MPA, to continued dispute (and continued communications) about the intent of the fees.
- On December 1, 2022 the Commission filed an injunction against TELUS Health, in particular TELUS' LifePlus Program alleging contraventions of the MPA.
- On February 1, 2023 the Commission filed an injunction against Harrison Healthcare alleging contraventions of the MPA.
- These two issues are now before the courts, at this time hearings have not been scheduled.

FINANCIAL IMPLICATIONS

- In its December 2022 report to Health Canada, BC reported Government Financial Information n extra billing charges for the 2020/21 fiscal year.
- As a result, BC's March 2023 Canada Health Transfer Payment will be reduced by this amount.
- The amount reported was based on patient complaints, extra billing audits, injunction reporting receive by the Commission, and estimated amounts of extra billing in private diagnostic facilities. This was the first year that reporting of extra billing in diagnostic facilities was required by Health Canada for all provinces/territories.

KEY BACKGROUND

- MSP is administered under the MPA and Regulations.
- The purpose of the MPA is to preserve a publicly managed insurance plan and a fiscally sustainable health care system in which access to necessary medical care is based on need and not an individual's ability to pay.
- The Commission pays for insured medical services (benefits) provided to residents of BC under MSP in accordance with the MPA. The MPA establishes rules regarding billing for services provided by physicians who are enrolled with MSP. In general, patients (or their representatives) must not be charged for benefits. The MPA also prohibits anyone from charging patients for *"materials, consultations, procedures, use of an office, clinic, or other place, or for any other matters that relate to the rendering of a benefit",* unless specifically permitted by the Commission.
- In 2018, the Government brought into force outstanding provisions of the Act, which enhanced the Commission's authority around extra billing (Bill 92).
- Unattached patients facing challenges with accessing primary care may be using these programs to get access to a physician.
- Private companies are attracting physicians away from the public health care system compounding existing, underlying systemic challenges with primary care and virtual care that are further enabling companies to set up these bundled services/programs in BC.

LAST UPDATED

The content of this fact sheet is current as of February 3, 2023 as confirmed by Stephanie Power, Executive Director.

APPROVALS

2023 02 12 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 02 17 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Northern Health Workforce Supports

Topic: Progress on Ministry-funded actopms to support service delivery and improve rural recruitment and retention in Northern Health Authority (NHA).

Key Messaging and Recommended Response:

- **We've taken actions to deliver health-care services when and where people need them including northern BC.**
- **In September 2021, we announced $6.3 million in funding to Northern Health Authority (NHA) to support programs and incentives that encourage more health workers to discover the advantages of working and living in the North. These actions, among many, include:**
  - **The Travel Resource Pool: a pool of health care workers to travel to high-needs areas in response to urgent staffing shortages.**
    - **Currently the TRP employs 101 RNs, LPNs, and RPNs. 28% of which have joined from outside BC and are net new to the workforce in the province.**
  - **The Prototype Rural Retention Incentive (PRRI): new incentive program has been introduced to heath care workers in NH that provides up to $2000 per quarter for high needs communities and occupations.**
    - **The PRRI has produced a net gain of 4.48 increase in regular baseline staff in participating communities.**
  - **Housing supports: to address housing in communities where suitable market housing is a barrier to permanent staffing and short-term deployments.**
    - **NHA has obtained 8 properties across four cities, and renovations are being done on existing units in Hazelton.**
  - **Childcare supports: a childcare program that supports expanded net new child care spots and expanded hours of operation to meet the needs of health-care workers, who are often working 12-hour shifts.**
    - **We've extended 40 childcare spots in Fort St. John, 12 spots are being added in Chetwynd, and 21 spots in Prince George. Expansion is being explored in 7 additional communities.**

- **These actions continue to address the recruitment and retention challenges that communities in northern BC experience.**

CURRENT SITUATION

- In September 2021, the Ministry of Health announced funding to NHA to fund actions to address health workforce challenges in Northern Health with a focus on the Northeast Health Service Delivery Area, Hazelton, and Prince Rupert.
- **The Prototype Rural Retention Incentive (PRRI)** – up to $2000 per quarter for high needs communities and occupations.
    - An average of 808 employees per quarter have received this incentive in Northern Health with 73 new external regular hires to these communities/professions since October 2021 (2.77% increase in regular workforce in targeted communities).
    - The incentive has since been expanded to Grand Forks (Interior Health) and Mt Waddington (Island Health) and a provincial expansion (including new policies and parameters) is being envisioned through the Provincial Health Human Resources Strategy (HHR Strategy).
- **The Travel Resource Pool (TRP) –** a pool of health care workers who can travel to high-needs communities in response to urgent staffing shortages.
    - Currently the prototype TRP employs 101 RNs, LPNs, and RPNs, 28% of which have joined from addresses outside BC and are net new to the provincial system.
    - The TRP has been used alongside the PRRI in Grand Forks and Mt Waddingron and a provincial expansion is being implemented through the HHR Strategy.
- **Housing supports –** a prototype to fund the procurement of housing units in communities where suitable market housing is barrier to permanent staffing and short-term deployments.
    - NHA has obtained 1 property in Kitimat, 3 units in Prince Rupert, 1 property in Dawson Creek, and 3 units in Fort St. John. Renovations to existing units are underway in Hazelton.
    - A provincial health sector housing strategy is being developed through the HHR Strategy.
- **Childcare support –** a prototype to support expanded net new childcare seats and expanded hours of operation to meet the needs of health care workers.
    - Underway in 3 communities (Fort St. John, Chetwynd, and Prince George), and being explored in 4 others (Kitimat, Hazelton, Prince Rupert, and Dawson Creek).
    - 40-spot extended childcare program live in Fort St. John.
    - 12 additional spots being added in Chetwynd and 21 spots in Prince George.
    - A provincial health sector childcare strategy is being developed through the HHR Strategy.
- **Clinical Management Supports –** prototype to increase clinical program management capacity to ensure workload and workforce sustainability
    - 12 positions created in Prince Rupert and the Northeast: clinical nurse educators, patient care coordinators, operations assistants, recruitment ambassadors, and HR assistants.
    - A provincial clinical management support framework and program expansion is being developed through the HHR Strategy
- **Terrace Obstetrical Care Services** – community fund to support appropriate care levels.
    - Recruited new members and retained the existing member resulting in service stabilization.

FINANCIAL IMPLICATIONS

Funding for several of these initiatives has been requested through the Ministry of Health's Budget 2023 submission in support of the Provincial Health Human Resources Strategy. Details of approved funding will be finalized on Budget Day – February 28, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Rural and remote communities in NHA have consistently had trouble with healthcare worker recruitment and retention.
- The COVID-19 pandemic increased strain on the workforce and exacerbated health workforce challenges in Northern Health.
- In 2021 the Ministry of Health met with NHA staff regularly to understand health workforce challenges in the North – especially in the Northeast Health Service Area, Hazleton, and Prince Rupert – to discuss immediate actions that could be taken to stabilize services.
- Starting in 2021/22, HLTH has provided $6.3 million to Northern Health Authority for programs and incentives to attract new health care workers and to retain existing workers.
    - Prototype Rural Retention Incentive (PRRI): HLTH has provided Northern Health with approximately $3 million to fund financial incentives and supports for priority health-care workers. The incentive was implemented in January 2022, retroactive to October 2021.
    - Travel Resource Pool (TRP): HLTH has provided $821,000 to continue and expand the Northern Health Travel Resource Pool, which directly contributes to service stability in rural and remote regions of the health authority.
    - Northern Health Housing Pilot: HLTH has provided $750,000 in funding so that Northern Health can develop a pilot housing program in communities where suitable market housing is barrier to both permanent staffing and short-term deployments.
    - Northern Health Childcare Pilot: HLTH has provided $225,000 in funding so that Northern Health can develop a pilot childcare program to meet the needs of health-care workers (especially those working 12-hour shifts).
    - Clinical Management Supports : HLTH has provided $645,000 in funding to Northern Health to create clinical management supports for Prince Rupert and the northeastern region.
    - Terrace Obstetrical Care Services: HLTH has provided a flexible community fund of $115,000 to support obstetrical care delivery by interdisciplinary teams at Mills Memorial Hospital in northwestern BC.
- The Ministry of Health has been working with Northern Health Authority and the other regional health authorities to determine priorities for expanding successful initiatives funded through the Northern Health Workforce Supports to become provincial in scope. Actions supported by the Provincial Health Human Resources Strategy that build on this work include:
    - Action 06 - Targeted Provincial Retention Incentive
    - Action 07 - Health Childcare Strategy and Childcare Pilot Expansion
    - Action 14 - Clinical Management Capacity Building
    - Action 34 - Provincial Travel Resource Pool
    - Action 42 - Provincial Health Sector Housing Strategy

LAST UPDATED

The content of this fact sheet is current as of February 17, 2023 as confirmed by Miranda Mason, Health Workforce Planning and Stragegic Initiatives.

APPROVALS

2023 02 22 – Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division.

LEGISLATIVE SESSION – ESTIMATES NOTE

Number of Health Professional Registrants by College or Registry

Topic: Health regulatory organizations provide information to the Ministry on the number of registrants currently registered including the number who are actively practising.

Key Messaging and Recommended Response:

- **The pandemic has intensified the strain on the entirety of the health-care system and has been tremendously difficult on our health-care workers.**
- **This is an issue that all jurisdictions are facing, nationally and internationally.**
- **Our Health Human Resources Strategy, announced in fall 2022, has 70 concrete actions focused on training, recruitment, and retention of health care workers.**
- **These actions address staffing capacity issues throughout the health-care system and will help alleviate the burden on our health-care workers.**
- **New education programs are being created, and current programs expanded, for more than 20 different health occupations, from nurses to midwives to health care assistants to physicians.**
- **In the last year we've seen the following increase in the health care workforce in the following professions. These numbers are for the total amount of practitioners, including practising and non-practising:**

Profession	2020/2021	2021/2022	Percentage increase
Physicans and Surgeons	2020/2021: 14,564	2021/22: 15,058	3.39%
Registered Nurses	2020: 44,072	2021: 46,721	5.7%
Licensed Practical Nurses	2020: 14,486	2021: 15,253	5.29%
Nurse Practitioner	2020: 712	2021: 825	15.87 %
Midwives	2020: 499	2021: 513	2.81%

- **The strain on the health-care system is not something that we will be able to fix overnight, but we are working to make changes as efficiently and effectively as poss**ible.

CURRENT SITUATION

Health regulatory organizations submit reports annually which provide information to the Ministry on the number of health professionals registered in the province among other details regarding regulatory operations.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

The following table contains the number of health professionals regulated under the *Health Professions Act* as well as Emergency Medical Assistants (EMAs) regulated under the *Emergency Health Services Act* and unregulated Health Care Aides (HCAs) that are registered in the Registry.[1]

Health Professions	Reporting Cycle	Practising Only	Total (all categories incl. non-practising)
Chiropractors[2]	2021/22	1,396	1,464
Dental Hygienists[3]	2021/22	N/A	4,538
Dental Surgeons[4]	2021/22	Dentists 3,941 Certified Dental Assistants 6,188	Dentists 4,101 Certified Dental Assistants 6,679
Dental Technicians[5]	2021/22	Dental Technicians 325	Dental Technicians 329 Dental Technician Assistants 427 Student 13
Denturists[6]	2021/22	254	261
Dietitians[7]	2021/22	1,469	1,508
Licensed Practical Nurse[8]	2021	14,893	15,253
Massage Therapists[9]	2021	5,676	5,888
Midwives[10]	2021	Midwives 357 Employed student midwife 84	Midwives 447 Employed student midwife 84
Naturopathic Physicians[11]	2021	711* *Excludes Student Registrants	860
Occupational Therapists[12]	2021/22	2,922	3,022
Opticians[13]	2021/22	911	993
Optometrists[14]	2022	938	940
Pharmacists[15]	2021/22	Pharmacists N/A Technicians 1,731	Pharmacists 6,654 Technicians 1,1747
Physical Therapists[16]	2021/22	N/A	4,372
Physicians and Surgeons[17]	2021/22	Family practitioners 7,229 Specialists 6,967	15,058 (this number includes a small number of podiatric surgeons as the total number of registrants outlined in the college's annual report includes both physicians and podiatric surgeons)

[1] Note that these numbers may differ from other numbers produced by the Ministry of Health because they count practitioners based on their registration status while the Ministry counts practitioners based on whether they received payment for service.
[2] College of Chiropractors of BC (2022). 2021-22 Annual Report. Retrieved March 23 2023 from College of Chiropractors of BC (chirobc.com)
[3] College of Dental Hygienists of BC (2022). 2021-2022Annual Report. Retrieved March 23 2023 from - British Columbia College of Oral Health Professionals (oralhealthbc.ca)
[4] College of Dental Surgeons of BC (2022). 2021-22 Annual Report. Retrieved March 23 , 2023 from British Columbia College of Oral Health Professionals (oralhealthbc.ca)
[5] College of Dental Technicians of BC (2021). 2020-21 Annual Report. Retrieved March 23 2023from British Columbia College of Oral Health Professionals (oralhealthbc.ca)
[6] College of Denturists of BC (2022). 2021-22 Annual Report. Retrieved March 23, 2023 from British Columbia College of Oral Health Professionals (oralhealthbc.ca)
[7] College of Dietitians of BC (2022). 2021-22 Annual Report. Retrieved March 23, 2023from College of Dietians of BC(collegeofdietitiansofbc.org)
[8] BC College of Nurses and Midwives (2022). 2021 Annal Report. Retrieved March 23, 2023 2023, from BCCNM 2021 Annual Report
[9] College of Massage Therapists of BC (2021). 2021 Annual Report. Retrieved March 23, 2023 from 2021-CMTBC-Annual-Report.pdf
[10] BC College of Nurses and Midwives (2022). 2021 Annual Report. Retrieved March 23, 2023, from BCCNM 2021 Annual Report
[11] College of Naturopathic Physicians of BC (2022). 2021 Annual Report. Retrieved March 23, 2023 College of Massage Therapists of BC
[12] College of Occupational Therapists of BC (2022). 2021-22 Annual Report. Retrieved March 23, 2023 from College of Occupational Therapists of BC
[13] College of Opticians of BC (2022). 2021-22 Annual Report. Retrieved March 23, 2023 from COBC-Annual-Report-2021-2022.pdfhttps://cobc.ca/wp-content/uploads/2022/07/COBC-Annual-Report-2021-2022.pdf
[14] College of Optometrists of BC (2021). 2021 Annual Report. Retrieved April 17, 2023from 2022 CDOBC annual report
[15] College of Pharmacists of BC (2022). 2021-22 Annual Report. Retrieved March 23, 2023 from https://library.bcpharmacists.org/2_About_Us/2-6_Annual_Reports/CPBC-Annual_Report_2021.pdf
[16] College of Physical Therapists of BC (2022). 2021-22Annual Report. Retrieved March 23, 2023 from 2021-2022-CPTBC-Annual-Report.pdf
[17] College of Physicians and Surgeons of BC (2022). 2021-22 Annual Report. March 23, 2023 from 2021-22-Annual-Report.pdf (cpsbc.ca)

Health Professions	Reporting Cycle	Practising Only	Total (all categories incl. non-practising)
Podiatric Surgeons[18]	2021/22	73	See above.
Psychologists[19]	2021	1,305	1,402
Registered Nurses[20]	2021	Registered Nurses 44,356 Employed student nurses 1,072 Nurse Practitioners 808	Registered Nurses 45,649 Employed student nurses 1,072 Nurse Practitioners 834
Registered Psychiatric Nurses[21]	2021	Registered Psychiatric Nurses 3,299 Employed student psychiatric nurses 39	Registered Psychaitric Nurses 3395 Employed student psychiatric nurse 39
Speech and Hearing Health Professionals[22]	2021	N/A	Audiologists 324 Hearing Instrument Practitioners 549 Speech Language Pathologists 1,459 Total: 2,058 (Note: the total is less than the combined number for each profession as many registrants are registered in two or three professions)
Traditional Chinese Medicine Practitioners and Acupuncturists[23]	2021/22	2,756	2,851
Emergency Medical Assistants[24]	January 30, 2023	N/A N/A	Paramedics 8,292 First Responders 7,204
Health Care Assistants[25]	January 19, 2023	N/A	46,265

LAST UPDATED

The content of this fact sheet is current as of April 17, 2023, as confirmed by Mark MacKinnon, Executive Director, Professional Regulation and Oversight.

APPROVALS

2023 04 17 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[18] College of Physicians and Surgeons of BC (2022). 2021/22 Annual Report. Retrieved March 23 2023 2021-22-Annual-Report.pdf (cpsbc.ca)

[19] College of Psychologists of BC (2022). 2021 Annual Report. Retrieved March 23, 2023 from http://collegeofpsychologists.bc.ca/docs/CPBC%20Annual%20Report%202021.pdf

[20] BC College of Nurses and Midwives (2022). 2021 Annual Report. Retrieved March 23, 2023, from BCCNM 2021 Annual Report

[21] BC College of Nurses and Midwives (2022). 2021 Annual Report. Retrieved March 23, 2023, from BCCNM 2021 Annual Report

[22] College of Speech and Hearing Health Professionals of BC (2022). 2021 Annual Report. Retrieved March 23, 2023 from https://cshbc.ca/wp-content/uploads/2022/09/2021-CSHBC-Annual-Report.pdf

[23] College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC (2022). 2021-22 Annual Report. Retrieved March 23 2023 from https://www.ctcma.bc.ca/media/2178/annual-report-2021-2022.pdf

[24] Emergency Medical Assistants Licensing Board (2023). Retrieved March 23, 2023 https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/colleges-boards-and-commissions/emergency-medical-assistants-licensing-board/emergency-medical-assistants-licensing-branch

[25] BC Care Aide & Community Health Worker Registry 2022 Year-End Update Report (confidential), January 19, 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

Nurse Practitioners

Topic: Demand for NPs has remained high since their introduction in 2005. As of January 2023, there are 869 NPs working in the Province.[1]

Key Messaging and Recommended Response:

- **We are dedicated to actions that grow, retain, and support nurse practitioners.**
  - **Under this government, the number of NP education seats at post-secondary institutions in BC has more than doubled, to 100 seats.**
  - **Most recently, in February 2022 we announced that the province is adding 20 nurse practitioner seats across post-secondary instutions in BC, including a new program for NPs at Thompson Rivers University.**
  - **It's worth noting that the number of NP seats remained static at 45 seats (in 2006) until its rapid increase under this government.**
  - **The government has committed to further NP seat expansions beyond the current 100 seats as part of the Provincial HHR Strategy.**
- **These actions to grow the NP workforce are making a difference to British Columbians:**
  - **The NP workforce in BC has more than doubled under the current government, from 418 NPs in 2017 to 869 NPs as of January 2023.**
  - **The NP workforce in BC has quadrupled since 2011. For reference, the population of BC grew by just 17% during the same period.**
  - **This rapid growth has resulted in BC's NP workforce growing at a rate that is faster than any other Canadian jurisdiction other than Quebec, where NPs have a much narrower scope of practice.**
  - **In 2020, 3 NP primary care clinics (NPPCCs) were opened in Nanaimo, Surrey, and Victoria, communities where a significant percentage of the population lacks access to a most responsible provider (MRP).**
    - **These clinics are expected to collectively attach ~20,225 previously unattached patients.**
    - **Independent research on the clinics conducted by the University of Victoria has shown that patients experience dramatic improvements**

[1] Provider and Location Registry data extract, January 11, 2023. NPs registered in BC but practicing outside of the province are filtered out, as are NPs with status code "terminated" or "suspended" (only "active" NPs are included).

in access to care, as well as improvements in their health, after attaching to an NP at an NPPCC.

- **Increasing NP training seats and investing in NP PCCs are just some of the ways we are taking action to increase health system capacity and service delivery in the province, ensuring that the people in BC receive the care that they need.**

CURRENT SITUATION

- Nurse Practitioners (NP) are an integral part of the new model of team based primary health care.[2]
- NPs have a background as registered nurses. Once they have gained a minimum of 2-3 years of clinical experience they then complete a clinically focussed master's degree which allows them to serve as autonomous practitioners in both primary and acute care.
- NPs have a broad scope of practice that includes:
  - Attaching, managing, and treating patients;
  - Conducting health assessments;
  - Ordering and interpreting diagnostic tests;
  - Managing acute and chronic illnesses or injuries;
  - Prescribing medication and other interventions; and
  - Referring patients to specialists and other care providers if needed.
- Primary care NPs are generally expected to carry a panel of 1,000 patients. Reductions to this target may occur if the NP serves rural/remote or priority populations.
- ~80% of NPs work in primary care, while ~20% serve in specialized acute and specialty care roles.[3] For example, this includes post-surgical cardiac care, oncology, NICU, etc.
- Standards, limits, and conditions for BC NPs are set by the BC College of Nurses and Midwives (BCCNM). These are found in the Scope of Practice for Nurse Practitioners section of the BCCNM website.[4]
- The vast majority of NPs work in publicly funded positions. NPs are paid a salary or hourly wage and do not submit fee-for-service claims like most physicians in BC. However, they must still submit encounter codes to the Ministry of Health (MoH) documenting their activities.
- Demand for NPs has remained high since their introduction in 2005. As of January 2023, there are 869 NPs working in the Province.[5]
- NPs in BC currently have two main compensation options: working as employees of health authorities (HAs) or, since 2018, as independent contractors on PCN service contracts. The latter is designed for providing longitudinal primary care and offers greater independence and remuneration in place of the extended benefits, leave, and coverage offered by HAs.
- The majority of NPs are employed by HAs, with approximately 220 currently working as contractors.[6]
- HA employed NPs receive practice supports from their employer, generally including personal and professional support, internal learning opportunities, and funding for continued education.
- PCN contracted NPs receive practice support through the Nurses and Nurse Practitioners of BC (NNPBC) professional association. These are: clinical coaching; advice, mentorship, and advocacy; quality improvement and assurance; funding for continuing professional development; and reimbursement for time spend participating in PCN committees or on approved continuing professional development activities.

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[2] For more information on MoH primary care policy, see the Primary Care Networks fact sheet.
[3] Based on an analysis of data submitted to the Ministry. BC Ministry of Health. Health Sector Workforce and Beneficiary Services Division. Nursing Policy Secretariat. Estimating % of NPs in primary care, end of FY20-21.xls
[4] *Scope of Practice for Nurse Practitioners* (BCCNM, September 2018). Retrieved January 14, 2021 from: https://www.bccnm.ca/NP/ScopePractice/Pages/Default.aspx
[5] Provider and Location Registry data extract, January 11, 2023. NPs registered in BC but practicing outside of the province are filtered out, as are NPs with status code "terminated" or "suspended" (only "active" NPs are included).
[6] Correspondence with the five BC regional health authorities.

- NPs in BC are educated at one of the Province's four NP programs (UVic, UBC, UNBC, TRU) or arrive with equivalent credentials. BC NP programs currently graduate ~80 students each year, with an additional 20 student seats to be added in 2023.
- The Nursing Policy Secretariat (NPS) was founded in 2017 to support the work of NPs and other nursing designations. This includes identifying and addressing legislative barriers to NP's SOP, such as amending the *Human Tissue Gift Act* so NPs can declare death for organ donors for the purpose of transplantation.
- In 2020, 3 NP primary care clinics (NP PCCs) were opened in Nanaimo, Surrey, and Victoria, communities where a significant percentage of the population lacks access to an MRP. They are expected to collectively attach ~20,225 previously unattached patients.[7]

FINANCIAL IMPLICATIONS

- From 2005/06 to 2021/22, the Province has provided approximately $397 million in funding for NP positions and supports.
- The MoH has made several large-scale investments to train, deploy, and support NPs, including:
  - Since 2012/13, the NP4BC program provided HAs with approximately $53.4 million to hire 135 primary care NPs;
  - In 2018, Government announced funding of approximately $115 million over three years for 200 (later increased to 300) NPs on PCN contracts[8]; and
  - From 2019/20 to 2021/22, the Ministry has provided approximately $3.2 million to the NNPBC to develop and deliver practice support programs for PCN contracted NPs and others who lack access to practice supports.

KEY BACKGROUND

The MoH has continually worked with BC's NP programs and PSFS to increase the number of student seats.

- In 2004, the first 30 placements were funded at UVic and UBC (15 each).
- In 2006, 15 additional seats were created with the founding of UNBC's NP program, making the total 45.
- The number of student seats remained static until being increased to 75 in 2018. This resulted from the Province's new policy of integrated team-based care and the creation of the PCN service contract.[9]
- 5 additional student seats were added to the UVic program in 2019/20.
- The number of NP students at BC's programs will reach 100 by 2023. This is a result of a further 5 seats being added to the UVic program and 15 new seats resulting from the launch of TRU's NP program.[10]

The MoH has also reduced the legislative/regulatory barriers that prevent NP's from achieving their full SOP.

- In 2011, *Bill 10* amended 12 acts and brought 11 others into force – all increased NP's SOP.
- In 2012, the *Hospital* and *Hospital Insurance Acts* were amended to permit NPs to admit/discharge.
- In 2014, *Bill 17* amended 9 additional acts to again increase NP's SOP.
- From 2015-2019, NPs became able to prescribe controlled drugs and opioid agonists, order diagnostic tests like MRIs, serve as medical assistance in dying assessors and prescribers, and affirm disabilities.
- As of February 1, 2023, sections of *Bill 10* were brought into force to amend the *Mental Health Act* to permit NPs to issue involuntary 48 hour holds for those whose mental health crises pose a serious risk to themselves or others.

LAST UPDATED

The content of this fact sheet is current as of March 20, 2023, as confirmed by Zachary Matieschyn, Executive Director, Nursing Policy Secretariat.

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[7] For more information about NP PCCs, please see the NP PCC Fact Sheet.
[8] Creating new opportunities for nurse practitioners as part of team-based care system. May 23, 2018. Retrieved January 14, 2021 from https://news.gov.bc.ca/releases/2018HLTH0034-000995
[9] https://news.gov.bc.ca/releases/2018HLTH0034-000995.
[10] https://news.gov.bc.ca/releases/2022HLTH0004-000250.

LEGISLATIVE SESSION – ESTIMATES NOTE

APPROVALS

2023 02 26 - Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 09 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 03 23 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Nurses' Bargaining Association Collective Agreement

(If Not Ratified)

Topic: The Nurses' Bargaining Association (NBA) and Health Employers Association of BC (HEABC) 2022-2025 Collective Agreement.

Key Messaging and Recommended Response:

Advice/Recommentations

- **So far, whether it be the new physician master agreement, the collective agreement with Health Sciences, or the collective agreement with Ambulance Paramedics and Dispatchers, we've demonstrated we want to work with health-care workers, because they are best-suited to help us out of some of the most difficult days we're facing as a health-care system.**

CURRENT SITUATION

- The NBA and HEABC commenced negotiations for a new collective agreement on December 8, 2022. The current NBA Collective Agreement expired March 31, 2022, but the terms and conditions remain in effect until a new agreement is reached.
- On March 31, 2023, HEABC and NBA reached a tentative agreement under the Shared Recovery Mandate. The NBA members voted to ratify the agreement, and on DATE, it was announced that the vote in favour was X%, therefore HEABC and NBA will continue negotiations.
- This tentative agreement included:
    - General wage increases (GWI):
        - April 1, 2022 $0.25 per hour increase then 3.24% GWI
        - April 1, 2023 6.75% GWI (includes 1.25% COLA)
        - Aprl 1, 2024 2.0% GWI plus up to 1.0% COLA
    - A suite of incentives to recruit, support and retain nurses in the BC public health care system
    - Indigenous specific anti-racism language consistent with other agreements, including:
        - Participation in the provincial forum on reconciliation and cultural safety for Indigenous employees;
        - Five (5) paid days leave for ceremonial, cultural, spiritual purposes for Indigenous employees
        - Changes to selection language to permit employers to preferentially hire indigenous employees, in specific situations
    - Participation on the new Provincial Health Human Resources Coordination Centre (PRHHCC) consultation forum for bargaining associations and in PHHRCC working group focused on diversity, equity, and inclusion.

- Additional investments will be made in nursing, building on BC's Health Human Resources Strategy, including:
    - Nursing workload standards (Nurse-to-Patient Ratios)
    - Ongoing funding to support:
        - Creation of new full-time permanent clinical mentorship positions
        - Additional point of care nursing supports
        - Expansion of the Employed Student Nurse program
        - Retention premium based on years of service for nurses in later stages of career
    - One-time funding to support:
        - Career laddering opportunities
        - Nurse Support Fund, which provides mental health and hardship support
        - Nurse-to-Patient Ratios implementation
        - Marketing and recruitment

FINANCIAL IMPLICATIONS

- The 2019-2022 NBA agreement represents an estimated $4.6 billion in annual expenditure on compensation. [1]
- The 2022-2025 agreement is expected to increase by the 2022 Shared Recovery Mandate including General wage increases (GWI):
    - April 1, 2022 $0.25 per hour increase then 3.24% GWI
    - April 1, 2023 6.75% GWI (includes 1.25% COLA)
    - Aprl 1, 2024 2.0% GWI plus up to 1.0% COLA

KEY BACKGROUND

- The 2019-2022 NBA Collective Agreement covers approximately 51,575 active employees, or 36,957 Full Time Equivalents (FTEs).[2]
- 50,538 employees and 98% of FTEs (36,311 FTEs) covered by the NBA are represented by the BC Nurses' Union (BCNU). Nurses are also represented by the Health Sciences Association (996 members, 633 FTEs), Hospital Employees' Union (27 employees, 6 FTEs), and BC Government and Service Employees' Union (7 members, 5 FTEs).[3]
- The NBA represents Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses (LPNs) in BC.

<u>2019 Bargaining Round (Sustainable Services Negotiating Mandate)</u>

- Highlights of the agreement include:
    - 3 year term (April 1, 2019 - March 31, 2022)
    - General wage increases of 2% per year over the term of the agreement.
    - An agreement on workload language to remove the inflexible and costly "will replace" language. This includes the new working short premium that has been established for nurses working in short-staffed units (See *Nurses Bargaining Association Supplementary Information* for more details).
    - A new short notice shift premium for straight-time shifts accepted within 24 hours of start time.
    - Working groups and committees to review pension and benefits plans.
    - A renewed commitment to workplace physical and psychological safety and violence prevention.
- The agreement was ratified by 54% of member votes.

[2] PSEC Public Sector Compensation Annual Forecast 2022 (unreleased) pg. 35.
[3] PSEC Public Sector Compensation Annual Forecast 2022 (unreleased) pg. 35.

LEGISLATIVE SESSION – ESTIMATES NOTE

Inclusion of Nurses in Presumptive Disability Legislation

The Inclusion of Nurses in Presumptive Disability Legislation, which extends the presumption under the *Workers Compensation Act* to employees working in certain occupations, came into effect April 16, 2019 for all nurses regulated by the BC College of Nurses and Midwives. These changes mean that nurses who are diagnosed with post-traumatic stress disorder, or other mental disorder, do not have to prove their condition resulted from work. This fast-tracks the claims process for accessing supports and compensation for those illnesses once a formal diagnosis has been made.

LAST UPDATED

The content of this fact sheet is current as of April 19, 2023 as confirmed by Evan Howatson, Labour and Agreement Branch.

APPROVALS

2023 03 21 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 20 - Mark Armitage,Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Nurses' Bargaining Association Collective Agreement

(If Ratified)

Topic: The Nurses' Bargaining Association (NBA) and Health Employers Association of BC (HEABC) 2022-2025 Collective Agreement.

Key Messaging and Recommended Response:

- **The Nurses' Bargaining Association (NBA) has ratified a new agreement under the Province's Shared Recovery Mandate.The NBA Provincial Collective Agreement covers approximately 51,500 registered, psychiatric and licensed practical nurses in BC.The majority of the nurses in the NBA are represented by the BC Nurses' Union, the Health Sciences Association, the Union of Psychiatric Nurses, the Hospital Employees' Union, and the BC General Employees' Union.**
- **The Shared Recovery Mandate supports government's key priorities to improve public services and the health-care system, while supporting the Province's continued economic recovery for all.**
- **This agreement includes significant policy-based initiatives as part of the Ministry of Health's overarching Health Human Resource Strategy which focuses on the importance to recruit, train, and retain healthcare workers.**
- **So far, whether it be the new physician master agreement, the collective agreement with Ambulance Paramedics and Dispatchers or this agreement with the NBA, we've demonstrated we want to work with health-care workers, because they are best-suited to help us out of some of the most difficult days we're facing as a health-care system.**

CURRENT SITUATION

The NBA and HEABC commenced negotiations for a new collective agreement on December 8, 2022 and reached a tentative deal on March 31, 2023. NBA members ratified the agreement by X% on X date.

2022 Bargaining Round (Shared Recovery Mandate)

- Highlights of the collective agreement are as follows:
  - General wage increases for all employees:
    - April 1, 2022 $0.25 per hour and then 3.24%
    - April 1, 2023 5.5% + 1.25% Cost of Living Adjustment (COLA)
    - April 1, 2024 2.0% + up to 1% COLA
  - Redesigned wage schedule to smooth increment steps and add an additional year (10th year)
  - Hourly service increments added 15 years ($0.50), 20 years ($0.75), 25 years ($1.00), and 30 years ($1.25);
  - New and increased shift premiums (see Appendix A for details)

  - Increase to the community business allowance
  - A commitment for employers to reimburse nurse college registration fees;
  - Deletion of the Patient Care Assessment Process (PCAP) and the Working Short Premium;
  - Indigenous Specific Anti-racism initiatives:
    - Participation in a new forum for dialogue on reconciliation between unions, HEABC, and Indigenous and other leaders within the Health Authority;
    - Changes to selection language to permit employers to preferentially hire indigenous employees, in specific situations
    - Five days of paid leave for ceremonial, cultural, and spiritual purposes for Indigenous empoyees;
    - unpaid leave to run for office in Indigenous governing entities and hold office in those entities
    - the addition of Indigenous definitions of immediate family to the terms of bereavement leave
  - Participation on the new PHHRCC consultation forum for bargaining associations and in PHHRCC working group focused on diversity, equity, and inclusion;
  - Continuation of the current Professional Responsibility process and the Strategic Nursing Staffing Committee (SNSC);
  - An expansion to voluntary shift exchanges and job share language to increase flexibility for nurses;
  - A small expansion of full-time steward and Enhanced Disability Management Program Representative positions;
  - Adding LPNs to the 1% Pension Fund (post-retirement benefits and enhanced inflation protection).
  - A significant expansion of clinical mentors
- Additional investments will be made in nursing, building on BC's Health Human Resources Strategy, including:
  - Nursing workload standards (Nurse-to-Patient Ratios)
  - Ongoing funding to support:
    - Creation of new full-time permanent clinical mentorship positions
    - Additional point of care nursing supports
    - Expansion of the Employed Student Nurse program
    - Retention premium based on years of service for nurses in later stages of career
  - One-time funding to support:
    - Career laddering opportunities
    - Nurse Support Fund, which provides mental health and hardship support
    - Nurse-to-Patient Ratios implementation
    - Marketing and recruitment

FINANCIAL IMPLICATIONS

- The 2019-2022 NBA agreement represents an estimated $4.6 billion in annual expenditure on compensation. [1]
- The 2022-2025 agreement increases by the 2022 Shared Recovery Mandate including General wage increases (GWI):
  - April 1, 2022 $0.25 per hour increase then 3.24% GWI
  - April 1, 2023 6.75% GWI (includes 1.25% COLA)
  - Aprl 1, 2024 2.0% GWI plus up to 1.0% COLA

KEY BACKGROUND

- The 2019-2022 NBA Collective Agreement covers approximately 51,575 active employees, or 36,957 Full Time Equivalents (FTEs).[2]

[2] PSEC Public Sector Compensation Annual Forecast 2022 (unreleased) pg. 35.

- 50,538 employees and 98% of FTEs (36,311 FTEs) covered by the NBA are represented by the BC Nurses' Union (BCNU). Nurses are also represented by the Health Sciences Association (996 members, 633 FTEs), Hospital Employees' Union (27 employees, 6 FTEs), and BC Government and Service Employees' Union (7 members, 5 FTEs).[3]
- The NBA represents Registered Nurses, Registered Psychiatric Nurses and Licensed Practical Nurses (LPNs) in BC.

Inclusion of Nurses in Presumptive Disability Legislation

The Inclusion of Nurses in Presumptive Disability Legislation, which extends the presumption under the *Workers Compensation Act* to employees working in certain occupations, came into effect April 16, 2019 for all nurses regulated by the BC College of Nurses and Midwives. These changes mean that nurses who are diagnosed with post-traumatic stress disorder, or other mental disorder, do not have to prove their condition resulted from work. This fast-tracks the claims process for accessing supports and compensation for those illnesses once a formal diagnosis has been made.

LAST UPDATED

The content of this fact sheet is current as of April 19, 2023 as confirmed by Evan Howatson, Labour and Agreement Branch.

APPROVALS

2023 03 21 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 20 - Mark Armitage,Health Sector Workforce and Beneficiary Services Division

[3] PSEC Public Sector Compensation Annual Forecast 2022 (unreleased) pg. 35.

LEGISLATIVE SESSION – ESTIMATES NOTE

Pathways to Practice for Internationally Educated Physicians

Topic: Internationally educated physicians (also referred to as International Medical Graduates or IMGs) who have received their medical training outside of Canada have several pathways to licensure in BC.

Key Messaging and Recommended Response:

- **This government prioritizes reducing barriers for international medical graduates (IMGs) while ensuring all physicians practicing in the province provide the high-quality health care British Columbians deserve.**
- **In November 2022, we announced additional actions to recruit more doctors by expanding pathways for IMGs to enter BC's workforce:**
    - **We further expanded the Practice Ready Assessment program. The program will triple from 32 seats to 96 seats by March 2024.**
        - **Since the program started in 2015, 188 IMGs have successfully completed it and have been placed in 57 communities across BC.**
    - **We introduced a new 'USA certified' class of licensure that provides a route for eligible US-trained physicians who hold certification in pediatrics, internal medicine, or emergency medicine to practice in community settings.**
    - **The new Associate Physicans classification provides a route for IMGs (who are not otherwise eligible for licensure as independent medical practitioners) to work under physician direction and supervision within a health authority acute-care setting.**
- **We know these investments in recruitment, retention, and training of IMGs are critical to improving patient access.**
- **The number of family physicians continues to grow. In the 2021/2022 fiscal year there were 4,451 IMGs practicing in BC. An additional 103 IMGs were granted provisional registration during this time.**

CURRENT SITUATION

- On November 27, 2022, government announced expanded pathways to practice for IMGs, including:
    - Expansion of the Practice Ready Assessment-BC Program (PRA-BC) from 32 to 96 seats by March 2024.

  - Expansion of the 'associate physician' class of licensure. Initial recruitment of associate physicians into accredited, health authority-based acute care settings is in-progress. Work is also underway to expand this new class so associate physicians can work in community primary care.
  - Introduction of a new 'USA certified' class of licensure that permits eligible US-trained physicians who hold American Board of Medical Specialists (ABMS) certification in emergency medicine, internal medicine, or pediatrics to practice in community settings in BC.
- On January 13, 2023, the College of Physicians and Surgeons of BC (CPSBC) amended their bylaws to create the 'associate physician – community primary care' and 'USA certified' classes of restricted licensure. Both of these licensure classes are intended as new pathways for individuals who do not otherwise meet requirements for full or provisional licensure.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Medical education varies widely among IMGs due, in part, to the varied selection, evaluation and credentialing processes in place at different international medical schools.
- To ensure IMGs meet the minimum Canadian medical standards for practice, all must complete a series of standardized assessments as identified by the national and provincial regulatory bodies.
- Physicians wanting to practice medicine in BC must be registered and licensed with the provincial regulatory body, the CPSBC. The role of the CPSBC is to ensure physicians meet expected standards of practice and conduct. The CPSBC's overriding interest is the protection and safety of patients.
- The CPSBC operates under the *Health Professions Act* (HPA) at arm's length from government. It is responsible for governing its registrants in accordance with the HPA, the Medical Practitioners Regulation, and the CPSBC bylaws. The CPSBC's responsibilities include registration, investigation, and resolution of complaints, and establishing standards of practice.
- The CPSBC relies on the national regulatory bodies, the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC), to determine if IMGs meet the appropriate national standards for certification.
- The initial screening of IMGs is often conducted by Health Match BC, the government funded recruitment service that guides IMGs through the licensure and registration process as well as provides information and guidance on immigrating to Canada.

There are several pathways to registration and licensure in BC:

- IMGs who have completed family medicine residency training in a jurisdiction approved by the CFPC and hold certification in family medicine in that jurisdiction (i.e., US, Australia, UK, and Ireland) may be granted provisional licensure from the CPSBC following an assessment of training and credentials.
- IMGs who have completed specialty training abroad, there are 29 international jurisdictions that the RCPSC has assessed and deemed to have met their standards. The IMG specialist is eligible to challenge the RCPSC specialty examination following an assessment from the RCPSC to confirm that the physician's training is substantially equivalent to Canadian training and has been satisfactorily completed. Not all specialties are approved in each jurisdiction.
- Family physicians licensed in countries that are not mutually approved by the CFPC can apply to the Practice Ready Assessment-BC Program (PRA-BC). Following successful completion of the 12-week PRA-BC assessment, and meeting other registration requirements, the IMG is eligible for provisional licensure to practice medicine in BC (see PRA-BC Fact Sheet).
- IMGs who have attained their undergraduate medical degree from a school listed on the 'World Directory of Medical Schools' can apply to UBC's Postgraduate Medical Education (PGME/residency) Programs. These IMGs compete for 58 IMG residency positions (52 family medicine; 6 specialty positions) through the Canadian Resident Matching Service (see IMG-BC Fact Sheet).
- The Practice Eligibility Route is a path available for IMGs who completed their postgraduate training outside of Canada and who have completed three years of practice in their specialty in any jurisdiction. The RCPSC

conducts a review of the specialist physician's practice and training to determine equivalence to Canadian training and grants access to exams. If the physician successfully passes the exams and meets all the requirements of the RCPSC and CPSBC, they can apply for eligibility for registration and licensure. After two years of practice in Canada as an independent specialist, the physician can apply for RCPSC certification which they require for continued registration and licensure.

- The 'associate physician' class of restricted licensure provides a new route for IMGs, who are not eligible for licensure as independent medical practitioners, to work under physician supervision in structured team-based care settings to increase capacity and service delivery. Implementation in acute-care is underway. Structures to support expansion to community settings are in development (see Associate Physician Fact Sheet).
- The new 'USA certified' class of restricted licensure provides a route for eligible US-trained physicians who hold ABMS certification in emergency medicine, internal medicine, or pediatrics to practice in community settings in BC. Structures to support implementation are in development.

Postgraduate Medical Education (PGME or Residency)

- Before an IMG can apply for residency training, they must satisfy several requirements, including a series of exams that test knowledge, skills, and aptitude for entry into Canadian residency programs.
- IMGs seeking to match to a residency position in BC are required to participate in UBC's one-day Clinical Assessment Program (CAP). The CAP provides a transparent and equitable process to assess a candidate's clinical experience, potential for success in residency, and suitability for working in communities across BC.
- Candidates matched to IMG positions complete a return of service (ROS) in a health authority-identified community of need upon completion of residency training. Family physicians complete a two-year ROS; all other specialists complete a three-year ROS.

Provisional Licensure

- An IMG granted a provisional license must have a sponsoring organization (such as a health authority) and a supervisor approved by the CPSBC.
- IMGs with provisional licensure are required to complete Canadian qualifying exams as outlined by the CPSBC within five years to advance to full licensure.
- If a provisional registrant does not meet the requirements within the time period (i.e., obtain certification with the CFPC/RCPSC), or there are substantive concerns from the supervisor or the sponsoring health authority, their provisional license may be cancelled. In some cases, the CPSBC will consider extenuating circumstances and may establish new exam deadlines.
- An applicant can request a review of their registration decision by the Health Professions Review Board.

LAST UPDATED

The content of this fact sheet is current as of February 16, 2023 as confirmed by Kevin Brown.

APPROVALS

2023 02 24 – Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Pharmacist Scope of Practice

Topic: The Province recently optimized pharmacists' scope of practice (SOP) in relation to their existing authority to renew and adapt prescriptions, and administer injections, and is working on regulatory amendments that will authorize pharmacists to prescribe for minor ailments and some forms of contraception in the spring of 2023.

Key Messaging and Recommended Response:

- **Our Health Human Resources Strategy commits to optimizing pharmacy services to support primary care by expanding pharmacist scope of practice and clinical autonomy:**
  - **As of October 14, 2022, pharmacists can now adapt and renew prescriptions for a wider range of drugs and conditions, and are able to administer, further to a prescription, a wider range of drugs by injection or intranasally.**
  - **This expansion of practice streamlines the process for patients to access medication by injections and intranasally, making it easier and faster for people to access the healthcare they need.**
- **In addition, the Ministry of Health is working with the College of Pharmacists of BC on regulations that will enable pharmacists to prescribe for minor ailments and contraception by June 1, 2023.**
- **The expansion of pharmacist practice helps patients access care more quickly, which helps take the pressure off our primary care system.**
- **This will result in family doctors having more capacity to support patients with other issues and provide better access to care for people.**

CURRENT SITUATION

- On September 29, 2022, Minister Dix announced a new health workforce strategy for BC, which included plans for the expansion of pharmacy services to improve healthcare access for British Columbians.
- As of October 14, 2022, BC pharmacists are authorized to:
  - Renew and adapt existing prescriptions for a wider range of medication types and conditions, including chronic diseases.
  - Renew prescriptions for narcotics, controlled drugs and targeted substances, for the same duration as originally prescribed (as permitted by a Health Canada temporary exemption to the federal *Controlled Drugs and Substances Act*).
  - Administer a wider range of prescribed drugs by injection and intranasal route;
- The valid period for prescriptions has been extended to two years, instead of one year.

- The Ministry is also working with the College of Pharmacists of BC (CPBC) to develop and implement regulatory changes that will enable pharmacists to prescribe medication for certain minor ailments and forms of contraception, which is expected to be implemented in the spring of 2023.
- This expansion in pharmacist SOP will better align BC with what is enabled in other provinces (i.e., all provinces authorize pharmacists to prescribe for a defined list of minor ailments, and some authorize pharmacists to prescribe contraception).
- The Ministry and the CPBC are undertaking policy work to support the decisions necessary to implement this new service (e.g., decision on a list of minor ailments and forms of contraception for BC, and the categories of drugs appropriate for BC pharmacists to prescribe).
- The policy work includes the following:
    - a cross-jurisdictional scan of what other provinces have authorized and implemented, including any considerations related to education/training, process development and funding of the service;
    - an assessment of curriculum content in the University of British Columbia's (UBC) PharmD program, and the potential need for any additional education/training to support BC pharmacists to provide this new service;
    - an assessment of the process requirements for service implementation, and funding model options to support uptake of this new service;
    - consultation with health stakeholders/partners (e.g., the health profession regulatory colleges with drug prescribing authority, and Indigenous partners); and
    - an assessment of the communication required to support successful implementation (e.g., for pharmacists, health stakeholders and the public).
- The Ministry is drafting amendments to the Pharmacists Regulation to create the legal authority for BC pharmacists to prescribe Schedule 1 drugs for certain minor ailments and forms of contraception. These amendments will be posted on the Professional Regulation website to allow for stakeholder/public feedback, prior to being formally filed and brought into force in spring 2023.
- The CPBC is drafting the necessary bylaw amendments and new standards to support pharmacists to safely deliver the new service and is also working with the BC Pharmacy Association to develop a mandatory education model on the regulatory changes. In order to prescribe for minor ailments and contraception, pharmacists will need to self-declare completion of the module.
- The CPBC's Annual Report for 2021/22[1] indicates there are 6,654 pharmacists practicing under full registration in BC, who could decide to complete the mandatory education module and begin prescribing for minor ailments and contraception. Uptake may be highest by community pharmacists.

FINANCIAL IMPLICATIONS

The Ministry is working on funding model options to support service uptake.

KEY BACKGROUND

- The Pharmacists Regulation currently authorizes BC pharmacists to prescribe for the purpose of emergency contraception only.
- Ontario is the most recent province to implement pharmacist prescribing for minor ailments. As of January 1, 2023, pharmacists in Ontario are authorized to prescribe for 13 minor ailments (e.g., conjunctivitis, and uncomplicated urinary tract infections).

LAST UPDATED

The content of this fact sheet is current as of February 7, 2023, as confirmed by Mark MacKinnon, Professional Regulations and Oversight Branch.

APPROVALS

2023 02 12 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[1] College of Pharmacists of British Columbia Annual Report 2021/2022, February 2022, p.24, Accessed Feb 1, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

Postgraduate Medical Education

Topic: Postgraduate (PGME or 'residency') and undergraduate medical education (UGME or 'medical school') programs are expanding across the province to help address BC's physician workforce requirements.

Key Messaging and Recommended Response:

- **Training more health care workers, including doctors, to deliver services for British Columbians is one of our top priorities.**
- **Our investments in recruitment, retention, and resident training are making a difference. The number of family physicians continues to grow.**
- **This government is supporting the further expansion of the University of BC's (UBC) undergraduate medical education (UGME) and postgraduate medical education (PGME/residency) training programs. These seats will be phased in throughout the province starting this year, 2023.**
- **The increase to UGME and PGME will bring the total student intake to 328 each year; up from 288.**

Advice/Recommentations

- **We are actively investing in the expansion of medical education. In 2021/22, this government allocated $163 million to support physician residency training in BC. In 2017, this number was $135 million.**
- **We have also announced an investment of up to $4.9 million to support the development of a new medical school at Simon Fraser University. SFU is working towards its first student intake by September 2026.**
- **These are just some of the many actions we are taking to address physician capacity issues in the health-care system to ensure that people in BC get access to the care they need.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- Between 2017 and 2022, HLTH allocated additional funding to support the expansion of **over 60 new annual residency positions** within key areas that include anesthesiology, family medicine, geriatrics, emergency medicine, palliative care, pediatrics, psychiatry and addictions, maternity, and cancer care.
- Beginning in 2023, the province is supporting further expansion of the University of BC's (UBC) UGME and PGME to deliver up to 128 new annual seats to help meet growing demand for physicians in BC.
    - **40 additional undergraduate medical school** seats will be phased-in over 2023/24 and 2024/25, to a total of 328 per year, a 14% increase above the current 288 intake:

UGME Program Name	University/City	2022 Intake	Expanded Intake
Vancouver-Fraser Program	University of BC – Vancouver	192	208 (+16)
Northern Medical Program	University of Northern BC - Prince George	32	40 (+8)
Island Medical Program	University of Victoria - Victoria	32	40 (+8)
Southern Medical Program	University of BC Okanagan - Kelowna	32	40 (+8)
	TOTAL	288	328

    - Advice/Recommentations

- HLTH's mandate includes supporting the Ministry of Post-Secondary Education and Future Skills (PSFS) mandate **to launch a new second medical school in BC** at a Simon Fraser University (SFU) location based in Surrey, with the aim to accept its first students by September 2026.

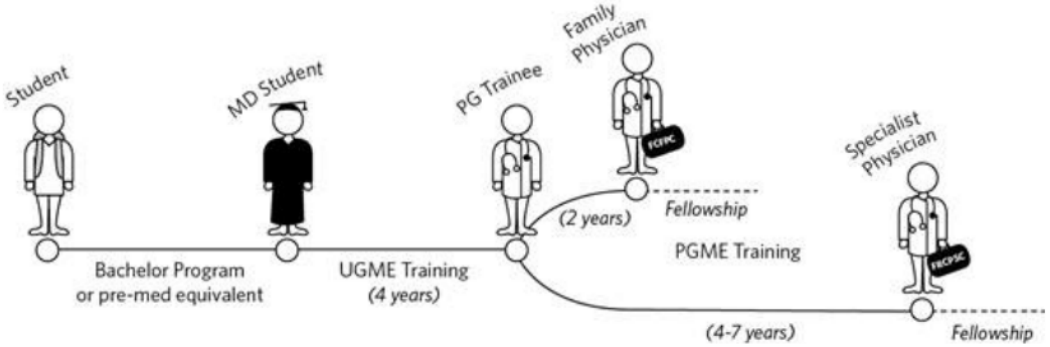
FINANCIAL IMPLICATIONS

- HLTH funds PGME residency training and PSFS funds UGME medical school education respectively.
- HLTH allocated $163 million to support PGME training in 2021/22, up from $135M in 2017/18.
- The Province is investing up to $4.9M to launch a new SFU medical school including initial planning activities and the development of a business case that is to be completed by May 31, 2023.

KEY BACKGROUND

- Advice/Recommentations

- Canadian medical education exists on a continuum that starts with UGME, resulting in an M.D. degree, and continues through to the completion of a PGME before a physician is eligible for licensure and independent practice. UGME is four years in duration, Family Medicine residency requires an additional two years of PGME, and Specialty/Fellowship residency requires four to seven or more years of PGME.



- Every student that completes pre-requisites while maintaining a high grade point average may apply to the 17 UGME schools across Canada. Entry is highly competitive with most successful applicants applying two or more times over consecutive years and to multiple schools before being accepted.
  - In some cases, a student may choose to also apply to UGME outside of Canada, with intention to return to Canada to compete for an International medical graduate (IMG) PGME position.
  - BC's UGME expansion creates more opportunities for students that may have been unable to secure a position and may therefore choosen to leave Canada to train at an international school.
- All UGME graduates must compete for PGME positions across Canada as part of a fair, transparent, and equitable Canadian Resident Matching Service (CaRMS) two round national matching process:
  - In BC, 58 PGME positions are protected exclusively for IMG applicants in the first round, and IMGs may also compete for all positions and specialties available in CaRMS second round.
- Between 2003 and 2022[1]:
  - UBC's UGME has expanded first-year intake from 128 (2003) to 288 (2022) seats per year.
  - UBC's PGME has expanded total intake from from 134 (2003) to 362 (2022) per year.
- In 2022, UBC's 362 total entry-level and advanced PGME positions were allocated as follows[2]:
  - 174 in family medicine and 188 across UBC's Royal College specialty training programs.
  - 58 IMG positions: 52 family medicine and six in Psychiatry, Internal Medicine, and Pediatrics
- Currently over 1400 residents provide health care as they train within various settings across BC:
  - Distributed training enables trainees to experience urban, rural, and remote clinical settings that also help build relationships and connections that influence future practice location.
  - The following table shows the number of PGME resident rotations by health authority[3]:

PGME Resident Rotations	FHA	IHA	NHA	VCH	VIHA
Specialist Rotations	669	191	90	1106	300
Generalist rotations	382	97	69	558	171
Family Medicine Rotations	142	100	61	172	115

- Medical education is contributing to the overall increase of BC's physician workforce
  - Long-term data indicates that over 93% of trainees who complete both UGME and PGME at UBC are choosing to stay and practice in BC upon completion of their medical training.[4]
- Government remains committed to its significant investment into BC's medical education system and it is expected that British Columbians will see increasing benefits as expanded cohorts of newly trained medical residents' transition into practice within BC's diverse communities across the Province.

[1] University of BC. Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2022). UGME – Practice Locations. Data as of October 2022.
[2] CaRMS. (2022). *R1- Data and Reports: Table 39.* https://www.carms.ca/data-reports/r1-data-reports/. Last accessed. September 15, 2022.
[3] University of BC. Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2022). PGME Clinical Placements. Data as of October 2022.
[4] University of BC. Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2022). Sankey. Data as of October 2022.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet was updated as of February 16, 2023 as confirmed by Kevin Brown, Executive Director, Physician Services Branch.

APPROVALS

2023 02 25 – Mark Armitage, Health Sector Workforce and Beneficiary Services
2023 03 06 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Practice Ready Assessment-BC for Family Physicians

Topic: Internationally trained family physicians (FPs), also referred to as International Medical Graduates (IMGs), who are licensed, practicing physicians in other countries, are often unable to qualify for a license to practice medicine in Canada. The Practice Ready Assessment BC (PRA-BC) program provides an alternative pathway to licensure in BC in exchange for a practice commitment in a health authority-identified community of need.

Key Messaging and Recommended Response:

- **This government prioritizes reducing barriers for international medical graduates (IMGs) while ensuring all physicians practicing in the province provide the high-quality health care British Columbians deserve.**
- **We expanded the Practice Ready Assessment (PRA-BC) program to further support IMGs.**
- **IMGs who are licensed, practicing physicians in other countries, are often unable to qualify for a license to practice medicine in Canada. The PRA-BC program provides an alternative pathway to full licensure in BC, for these IMGs.**
- **The program also directly supports British Columbians by providing access to physician care. Successful PRA-BC applicants provide a three-year return of service (ROS) in a health authority-identified community of need.**
- **The PRA-BC program will triple from 32 seats to 96 seats by March 2024.**
- **As of March 23, 2023, 204 IMGs have successfully completed the PRA-BC program and have been placed in 59 communities across BC.**
- **This is just one of the many ways in which we are taking action to ensure that British Columbians have access to they care they need, while supporting IMG's to practice in the province.**

CURRENT SITUATION

- PRA-BC currently assesses at a rate of 32 physicians per year comprised of a Spring and Fall intake. Successfully assessed candidates are distributed to rural communities (16) and to Primary Care Networks (16), which may be urban, semi-urban or rural communities.
- Government recently announced the expansion of the Program from 32 to 96 seats by March 2024.
- Work is underway with health system partners to enhance program supports to enable expansion and the successful integration of more IMGs into the health system.

FINANCIAL IMPLICATIONS

In 2022/23, the Ministry committed $2.54M to support PRA-BC assessments.[1]

[1] HEABC Funding Letter dated September 14, 2021. Funding through both Ministry and through the Joint Standing Committee on Rural Issues – a collaborative committee of the Ministry and Doctors of BC

KEY BACKGROUND

- There are 3 pathways to practice medicine in BC for internationally trained FPs who are licensed, practicing physicians in other countries:
  1. FPs who hold an undergraduate medical degree from a school listed on the 'World Directory of Medical Schools' can apply to UBC's Postgraduate Medical Education (residency) Programs through the Canadian Resident Matching Service.
  2. FPs who have completed an accredited postgraduate family medicine training program in one of the four approved jurisdictions acceptable to the College of Family Physicians of Canada (CFPC) who also hold certification in family medicine in that jurisdiction (i.e., US, UK, Ireland, and Australia), may be granted provisional licensure from the College of Physicians and Surgeons of BC (CPSBC) following an assessment of training and credentials.
  3. FPs licensed in countries that are not mutually approved by the CFPC can apply to the PRA-BC program to complete a 3-month assessment and following successful completion may be eligible for provisional licensure with the CPSBC to practice medicine in BC.
- Candidates in the PRA-BC program participate in a 2-week centralized orientation in Vancouver followed by a 12-week Clinical Field Assessment under the supervision of a fully licensed FP in a BC community. With the successful completion of the Clinical Field Assessment, a candidate is eligible for provisional licensure with the CPSBC.
- PRA-BC follows a standardized format approved by the Medical Council of Canada's National Assessment Collaboration (NAC). The format meets the medical regulatory authorities' provisional licensure requirements across Canada, aligned with the Agreement on Internal Trade which enables interprovincial labour mobility. Organizations participating on NAC include federal and provincial health ministries, faculties of medicine, medical regulatory authorities, and regional IMG assessment programs.
- PRA-BC is funded by both the Ministry of Health and the Joint Standing Committee on Rural Issues, a partnership between the Ministry and Doctors of BC.
- PRA-BC supports improved access to FPs by requiring successful applicants to provide a three-year return of service (ROS) in a health authority-identified community of need.
- As of March 23, 2023, 204 IMGs have successfully completed the PRA-BC Program and have been placed in 59 ROS communities[2] across BC. Placements by health authority are as follows:

Health Authority	Placements
Northern Health	74
Interior Health	57
Island Health	44
Vancouver Coastal Health	15
Fraser Health	14
Total Placements	204

- ROS placements by cohort year since program inception[3]:

Year	Placements
2015	25
2016	30
2017	32
2018	25
2019	14
2020	16
2021	33
2022	29
Total Placements	204

[2] Physician Workforce Development; Health Sector Workforce and Beneficiary Services Division. PRA-BC community placements 20230323.
[3] Ibid.

LEGISLATIVE SESSION – ESTIMATES NOTE

Historical Background

- Until 2012, the CPSBC conducted a paper-based assessment of internationally-trained physicians requiring a practice assessment.
- Due to changes to the Agreement on Internal Trade in 2009, the CFPC began work on pathway 1 (i.e., enabling licensure of FPs from the US, Australia, UK, and Ireland), and NAC began work on pathway 2: a practice assessment for FPs.
- In 2013, NAC finalized the PRA for internationally trained FPs. A pathway for internationally trained specialists has not yet been established.

LAST UPDATED

The content of this fact sheet is current as of February 16, 2023 as confirmed by Kevin Brown, Executive Director, Physician Services Branch.

APPROVALS

2023 02 24 – Stephanie Power obo Mark Armitage, Health SectorWorkforce and Beneficiary Service
2023 03 06 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Provincial Health Human Resources Strategy

Topic: Provide an update on BC's Provincial Health Human Resources Strategy including 70 actions organized under four cornerstones: retain, redesign, recruit, and train.

Key Messaging and Recommended Response:

- **Our Health Human Resources (HHR) Strategy, announced in fall 2022, has 70 concrete actions focused on training, recruitment, and retention of health care workers.**
- **We began work on these actions in 2022 and will continue implementation through 2023.**
- **These actions address staffing capacity issues throughout the health-care system and will help alleviate the burden on our health-care workers.**
- **Budget 2023 provided investments of $1 billion over three years to support the actions laid out in our HHR workforce strategy.**
- **We've opened up several avenues to increase the numbers of nurses, physicians, and allied health care professionals, both those trained here in BC and those trained in other provinces and countries.**
- **New education programs are being created, and current programs expanded, for more than 20 different health occupations. For example:**
    - **In February 2023, the Province expanded the midwifery program at the University of BC by 20 seats, which is an increase of over 70%.**
    - **The further expansion of UBC's medical school (beginning in 2023) and its postgraduate medical residency training programs to deliver a combined 128 new seats annually.**
    - **In addition, we've funded a significant expansion of nursing seats – a total of 602 - at public post-secondary institutions across BC.**
- **We have also added a total of 270 new ongoing allied health seats to BC's public post-secondary institutions, as well as additional one-time support to meet immediate training needs for Medical Laboratory Assistants and a new program to help internationally educated Advanced Care Paramedics join the workforce.**

- **Growing these programs, investing in, and increasing BC's supply of highly skilled graduates will ensure the province has the right health professionals in the right places so that British Columbians can access the health services they need now and in the future.**

CURRENT SITUATION

- In September 2022 the Ministry of Health received Cabinet endorsement and released BC's Provincial Health Human Resources Strategy.
- The Ministry was invited to Treasury Board to seek funding to support implementation of the strategy. A significant investment was approved by Treasury Board on December 1, 2022 – to be publicly communicated on February 28, 2023 as part of the Budget 2023 announcement.
- To provide governance and oversight of the Strategy and coordinate action on urgent and long-term health workforce issues, the Ministry of Health established the Provincial Health Human Resources Coordination Centre (PHHRCC).
    - PHHRCC includes membership from the Ministry of Health, regional health authorities (HAs), the Provincial Health Services Authority, the Health Employers Association of BC (HEABC), Providence Health Care, and the First Nations Health Authority.
- Government has announced early actions to address immediate workforce pressures:
    - 01 – Occupational Health and Safety Resources – October 24, 2022
    - 03 – Relational Security Officers – October 24, 2022
    - 09 – Wage Levelling in Long Term Care and Assisted Living – December 16, 2022
    - 23 – Associate Physician Deployment Expansion – November 27, 2022
    - 25 – Emergency Medical Assistant Scope of Practice Expansions – September 29, 2022
    - 26 – Optimize Pharmacy Services to Support Primary Care – September 29, 2022
    - 36 – Internationally Educated Nurse Assessment and Nurse Re-Entry Support Program – January 9, 2023
    - 37 – Internationally Educated Allied Health Assessment Support Program – July 19, 2022
    - 41 – Practice Ready Assessment Program Expansion – November 27, 2022
    - 43 – New to Practice Incentive Program – October 31, 2022
    - 59 – Post Graduate Medical Education Expansion – September 29, 2022
    - 60 – Develop Second Medical School – November 28, 2022
    - 63 – Undergraduate Medical Education Expansion – September 29, 2022
    - 69 – Health Education Expansion Implementation – February 20, 2022 (Nursing); July 19, 2022 (Allied Health); February 17, 2023 (Midwifery)
- The Ministry of Health has committed to annual public reports on progress against this strategy as well as regular internal reports to support monitoring and evaluation. These reports will be endorsed by PHHRCC and developed in collaboration with key system partners including action implementation leads.

FINANCIAL IMPLICATIONS

Budget 2023 provides targeted investments of $1 billion over three years to support the Province's health workforce strategy as announced in September 2022.

KEY BACKGROUND

- Government has made significant investments in the health workforce over the past 5 years – resulting in an increase of over 38,000 employees since 2017. However, new investments are required to continue growing the workforce to meet current and future needs for health services.
    - Health sector workers are experiencing rising levels of stress and burnout, high turnover, increasing time to fill vacancies, early retirements, elevated overtime, and short staffing. Recently, media and

public attention has highlighted pressures across the health system, including in primary care, emergency departments, ambulance services, in patient care, and critical care.
    - BC's health sector employs more than 222,000 people (45% of public sector workers) and health workforce compensation exceeds $19.6B (80% of BC's health budget and 51% of public sector compensation).[1]
    - Health services are a major driver of the economy and must keep pace with economic growth to ensure that new entrants to the labour force have access to a strong, responsive health care system.
    - WorkBC estimates that by 2031 there will be more than 142,900 job openings in BC's health sector[2] and HLTH estimates that demand for health services will grow by 26% as populations age and health conditions become more complex.[3]
    - 80% of BC's health workforce are women[4] and only 2.5% are Indigenous[5] – both currently earn less than men for the same work.[6] Investments are needed to improve working conditions, wages, and representation for women, Indigenous people, and other equity seeking groups.
    - BC's health workforce grew by 20.7% over the last 5 years (an increase of 38,312 employees since 2017).[7] However, new investments are required to continue growing the workforce to meet current and future needs for health services.
- The Strategy articulates the framework, vision, principles, and objectives needed to help address these issues, including 70 actions under four cornerstones:
    - Retain: Foster healthy, safe, and inspired workplaces
    - Redesign: Optimize and Innovate
    - Recruit: Attract and Onboard
    - Train: Create accessible career pathways
- Indigenous Health and Reconciliation is as one of the foundational principles of the Strategy – underlying all other principles and governing the implementation of all 70 actions.
    - PHHRCC is committed to implementing the Declaration on the Rights of Indigenous Peoples Act and recommendations outlined in In Plain Sight (IPS), as embedding anti-racism in all work.
- The Strategy, which was endorsed by Cabinet on September 21, 2022, and released to the public on September 29, 2022, **envisions a health system that puts people first – fostering workforce satisfaction and innovation to ensure health services are accessible to everybody in BC, now and into the future.**

LAST UPDATED

The content of this fact sheet is current as of February 22, 2023 confirmed by Miranda Mason, Executive Director, Health Workforce Planning and Strategic Initiatives Branch.

APPROVALS

2023 02 24 - Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 02 - Heather Richards obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03 21 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[1] Public Sector Employers Council. (2022). Public Sector Annual Compensation Forecast
[2] Work BC. (2021). 2021 Labour Market Outlook.
[3] Health Sector Information Analytics and Reporting Division – BC Ministry of Health. (2021). Health System Matrix version 13
[4] BC Women's Health Foundation. (2020). Unmasking Gender Inequity.
[5] Mary Ellen Turpel-Lafond (Aki-kwe). (2020). In Plain Sight.
[6] Statistics Canada. (2022). 2016 Census of Population, Statistics Canada Catalogue no. 98-400-X2016294.
[7] Public Sector Employers Council. (2022, 2021, 2019, 2018). Public Sector Annual Compensation Forecast

LEGISLATIVE SESSION – ESTIMATES NOTE

Psychological Health and Safety in the Health Care Workplace

Topic: The Ministry's *Provincial Strategy for Health Human Resources* (2015) requires health authorities to create engaged, healthy, and well-led workplaces, through supporting the psychological well-being of health care workers and adopting the Canadian Standards Association (CSA) Group's National Standard for Psychological Health and Safety in the Workplace (Standard).

Key Messaging and Recommended Response:

- **The psychological health and safety of health-care workers is an important priority for the government of BC.**
- **In partnership with the health authorities, the Health Employers Association of BC, the unions, and Doctors of BC, the Ministry of Health continues to work towards improving the psychological well-being of health care workers through the Psychological Health and Safety Steering Committee (PHS SC).**
- **The Committee is working to implement the Canadian Standards Association (CSA) Group's National Standard for Psychological Health and Safety in the Workplace.**
- **SWITCH BC, an organization focused on the health, safety, and wellbeing of everyone working in healthcare in BC founded in 2019, is taking on a leadership role in this work.**
- **All health authorities, including Providence Health Care and the First Nations Health Authority, are working towards implementing the standard.**

CURRENT SITUATION

National Standard – Psychological Health and Safety in the Workplace

- The Psychological Health and Safety Steering Committee (PHS SC) was established in 2016, and comprises members representing the Ministry, Health Employers Association of BC, health authorities (including Providence and the First Nations Health Authority), unions, and Doctors of BC.
- The role of PHS SC is to:
    - Provide a collaborative forum to build strategies that support the psychological well-being of health care workers, and promote engaged, healthy, and well-led workplaces;
    - Inform planning, implementation, and evaluation processes of the Standard; and
    - Establish lines of communications between stakeholder organizations.
- The health authorities are at various stages of implementing of the Standard.
- The *Implementation of the National Standard on Psychological Health and Safety in the Workplace* policy directive (2017) is undergoing review as of January 2023.

- The independent SWITCH BC is assuming a leadership role in the provincial work to implement the Standard in 2023. Discussions are underway on how to revise the governance structure to strengthen accountability for this work.

Total Count of Psychological Incident Claims Submitted to WorkSafeBC, by HA, from Jan 2018-Dec 2022[1]

Health Authority	2018	2019	2020	2021	2022[2]	% Change from 2018-2021
BC Emergency Health Services	132	194	209	274	185	107.6%
Fraser Health	58	91	98	143	99	146.5%
Interior Health	63	88	71	107	93	69.8%
Island Health	74	92	105	147	158	98.6%
Northern Health	17	28	15	40	18	135.3%
Providence Health Care	13	22	22	34	32	161.5%
Provincial Health Services Authority	24	32	24	28	31	16.7%
Vancouver Coastal Health	42	52	83	78	63	85.7%
Grand Total	**423**	**599**	**627**	**851**	**679**	**101.2%**

Total Rate of Psychological Incident Claims Submitted to WorkSafeBC (per 100FTE), by HA, from Jan 2018-Dec 2022[3]

Health Authority	2018	2019	2020	2021	2022[4]	% Change from 2018-2021
BC Emergency Health Services	4.06	5.97	6.40	8.01	4.9	97.3%
Fraser Health	0.29	0.45	0.44	0.57	0.40	96.6%
Interior Health	0.42	0.56	0.45	0.64	0.56	52.4%
Island Health	0.49	0.58	0.60	0.77	0.81	57.1%
Northern Health	0.29	0.46	0.24	0.61	0.28	110.3%
Providence Health Care	0.24	0.40	0.38	0.56	0.52	133.3%
Provincial Health Services Authority	0.20	0.25	0.18	0.20	0.21	0%
Vancouver Coastal Health	0.26	0.32	0.46	0.39	0.31	50%
Grand Total	**0.78**	**1.12**	**1.14**	**1.47**	**1**	**88.5%**

Total Cost of Psychological Incident Claims Submitted to WorkSafeBC, by HA, from Jan 2018-Dec 2022[5]

Health Authority	2018	2019	2020	2021	2022[6]	% Change from 2018-2021
BCEHS	8,046,871	14,898,958	9,640,817	10,113,860	3,993,695	25.7%
Fraser Health	1,950,157	2,691,399	2,688,362	5,217,459	1,562,655	167.5%
Interior Health	2,154,821	3,394,407	2,364,767	3,542,551	1,459,555	64.4%
Island Health	3,022,865	3,967,431	4,574,789	5,986,134	2,686,154	98%
Northern Health	736,656	972,579	383,384	1,312,385	162,446	78.2%
PHC	379,270	1,900,875	1,868,381	986,392	386,843	160.1%
PHSA	849,418	2,190,381	1,303,089	898,275	396,613	16.7%
VCH	1,080,280	1,933,651	2,792,768	2,179,210	828,036	101.7%
Grand Total	**$18,220,335**	**$31,949,682**	**$25,616,357**	**$30,236,265**	**$11,475,998**	**66%**

[1] Data provided by OHS Solutions, February 09, 2023
[2] WSBC metrics include both active accepted and closed claims; hence 2022 claims numbers are lower than previous years as claims are still active and may not yet be adjudicated.
[3] Data provided by OHS Solutions, February 09, 2023
[4] WSBC metrics include both active accepted and closed claims; hence 2022 claims numbers are lower than previous years as claims are still active and may not yet be adjudicated.
[5] Data provided by OHS Solutions, February 09, 2023
[6] WSBC metrics include both active accepted and closed claims; hence 2022 claims numbers are lower than previous years as claims are still active and may not yet be adjudicated.

Total Days Lost of Psychological Incident Claims Submitted to WorkSafeBC, by HA, from Jan 2018-Dec 2022[7]

Health Authority	2018	2019	2020	2021	2022[8]	% Change from 2018-2021
BC Emergency Health Services	19,922	34,149	28,438	38,190	15,958	91.7%
Fraser Health	4,993	10,556	10,637	22,504	7,751	351%
Interior Health	7,412	11,228	7,481	16,655	7,365	124.7%
Island Health	10,349	12,143	16,113	26,816	13,508	159%
Northern Health	2,175	2,130	2,048	6,376	612	193%
Providence Health Care	830	5,244	5,126	4,545	1,863	448%
Provincial Health Services Authority	2,728	5,945	4,000	4,508	2,238	65.2%
Vancouver Coastal Health	4,431	6,502	10,324	9,893	4,275	123.3%
Grand Total	**52,840**	**87,897**	**84,167**	**129,487**	**53,570**	**145%**

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Mental Disorder Claims under the *Workers Compensation Act*

Under the *Mental Health Disorder Presumption Regulation,* eligible workers who are diagnosed with a mental disorder such as post-traumatic stress disorder, do not have to prove their condition resulted from their employment. The regulation lists the following health sector occupations as eligible under the presumptive clause: emergency medical assistants (e.g., paramedics), emergency dispatchers[9], nurses regulated by the BC College of Nursing Professionals, and health care assistants registered with the BC Care Aide & Community Health Worker Registry and employed in a publicly funded organization or setting.[10]

LAST UPDATED

The content of this fact sheet is current as of March 24, 2023 as confirmed by Mark Armitage.

APPROVALS

2023 03 09 - Peter Klotz, Regional Grants and Decision Support
2023 03 24 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[7] Data provided by OHS Solutions, February 09, 2023
[8] WSBC metrics include both active accepted and closed claims; hence 2022 claims numbers are lower than previous years as claims are still active and may not yet be adjudicated.
[9] Whose duties include receiving 911 calls from the public, and/or dispatching firefighters, police and ambulance services.
[10] The presumptive clause for the listed occupations came into effect on April 16, 2019.

LEGISLATIVE SESSION – ESTIMATES NOTE

Registered Nurse - Registered Psychiatric Nurse
Opioid Agonist Therapy (OAT) Prescribing

Topic: Enabling Registered Nurses (RNs) and Registered Psychiatric Nurses (RPNs) prescribing to increase access to evidence-base treatment for opioid use disorder, reduce barriers, and mitigate the risk of illicit drug toxicity death for British Columbians related to the increasingly toxic drug supply in BC.

Key Messaging and Recommended Response:

- **In September 2020 we announced a new public health order issued by Dr. Bonnie Henry, provincial health officer, to increase the number of health professionals authorized to prescribe safer pharmaceutical alternatives to the toxic street drug supply. This expansion included registered nurses and registered psychiatric nurses with the aim of making sure BC's health system is well equipped to meet people's needs to save more lives amidst the growing overdose crisis**
- **This order aimed to reduce substance use harms by reducing peoples' reliance on the illicit drug supply, and improving access to ongoing care, treatment and support.**
    - **The first prescriptions were written in March 2021 and the program continues to expand.**
    - **As of January 2023, 226 RNs and RPNs from all health authorities have enrolled and 105 have fully completed their training.**
    - **Additional RN/ RPN prescribers will continue to be trained across the health authorities support increased access to evidence-based treatment for opioid use disorder across the province, with a focus on rural communities.**
    - **Since 2020/21, we've allocated up to $2.09 million to the health authorities that support access to RNs and RPNs who prescribe pharmaceuticals to reduce the risk of overdose.**
- **These actions have the potential to save lives in the context of dual public health emergencies and helps to address inequities in access to treatment and substance use care for opioid use disorder, particularly in rural and remote communities with limited or no access to prescribers.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- In September 2020, in response to an increase in the number of illicit drug toxicity deaths, the Provincial Health Officer (PHO) issued an order temporarily expanding the scope of practice of Registered Nurses (RNs) and Registered Psychiatric Nurses to prescribe controlled drugs and substances including OAT and pharmaceutical alternatives to the illicit drug supply
- This order aimed to reduce substance use harms by reducing peoples' reliance on the illicit drug supply, and improving access to ongoing care, treatment and support.
- Implementation of nurse prescribing is proceeding in a phased approach and is currently focussed on nurse prescribing for the treatment of opioid use disorder. Phase one focused on prescribing buprenorphine/naloxone (Suboxone); phase two expands to prescribing other opioid agonist treatment (OAT) medications, such as methadone and slow-release oral morphine. Future phases will include prescribed safer supply medications.
- The first prescriptions were written in March 2021 and the program continues to expand.
- As of January 2023, 226 RNs and RPNs from all health authorities have enrolled and 105 have fully completed their training.[1]
- Additional RN/ RPN prescribers will continue to be trained as health authorities support increased access to evidence-based treatment for opioid use disorder across the province, with a focus on rural communities.
- Nurse prescribing is being implemented in collaboration with First Nations communities.
- Due to the ongoing illicit drug toxicity crisis and health human resources challenges, a permanent scope of practice change for RNs and RPNs is being worked on to permanently allow a new category of certified practice RNs and RPNs to treat Opioid Use Disorder using the prescription of controlled drugs.
- The process is underway to make the required regulatory amendments, and for the BC College of Nurses and Midwives to establish the required certification programs for RNs and RPNs authorized in the regulations. The new certification programs are expected to be operational in the fall of 2023.

FINANCIAL IMPLICATIONS

- Since 2020/21, the Ministry has allocated up to $2.09 million to the HAs support access to RNs and RPNs who prescribe pharmaceuticals to reduce the risk of overdose.
- The Ministry has allocated Providence Health Care $10.8 million from 2020/21 to 2022/23 to support BCCSU to provide clinical management for substance use disorders.

KEY BACKGROUND

- Providing people with low barrier and accessible opioid agonist treatment has the potential to save lives in the context of dual public health emergencies and helps to address inequities in access to treatment and substance use care for opioid use disorder, particularly in rural and remote communities without or limited access to prescribers.
- In February 2021, the first cohort of RN/RPN prescribers began prescribing buprenorphine/ naloxone (Suboxone®), a first in Canada.[2]
- To enable this practice, the Ministry of Health in partnership with the Ministry of Mental Health and Addictions (MMHA), and health authority (HA) clinical operations leads, developed clinical guidance and education to support RNs/ RPNs in management of persons with opioid use disorders.
- In March 2021, the BC College of Nurses and Midwives (BCCNM) released prescribing standards, limits and conditions, along with limits and conditions to enable "prescribing treatment for opioid use disorder" by RNs/ RPNs[3]. This expands on the BCCNM standards, limits, and conditions, to regulate RNs and RPNs in prescribing buprenorphine/ naloxone which came into effect on October 26, 2020.

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[1] Ministry of Mental Health and Addictions. February 10, 2023. Jill Murray, Director, Strategic Director Overdose Strategic Priorities personal communications.

[2] https://news.gov.bc.ca/releases/2021MMHA0003-000219

[3] BC College of Nurses and Midwives. Retrieved from: www.bccnm.ca/RN/learning/scope/prescribing/Pages/oud.aspx

- In November 2021, a new training pathway was also launched to support prescribing of additional OAT medications (methadone and slow-release oral morphine (Kadian).
- Nurse prescribers are working in multiple settings including mental health and substance use programs, outreach, and harm reduction services where they engage with people who are often not formally connected to care.
- Oversight for this initiative is supported by fulsome governance structures including a
    - **Steering Committee** -led by the Ministry and MMHA with representation from Office of the Provincial Health Officer, BC College of Nurses and Midwives, and BC Centre for Substance Use (BCCSU);
    - **Implementation Committee** – led by the Ministry and MMHA, composed of diverse representation inclusive of BCCSU, BCCNM and health authority leads;
    - **Scope and Education Committee -** led by BCCSU and composed of clinical addiction experts, operational stakeholders, MMHA, HLTH and BCCNM; and an
    - **Evaluation Working Group** – led by MMHA. Monthly meetings with health authority operation leads to support evaluation planning at a regional level.

LAST UPDATED

The content of this fact sheet is current as of February 13, 2023 as confirmed by Zachary Matieschyn, Executive Director, Nursing Policy Secretariat.

APPROVALS

2023 02 22 - Stephanie Power obo Mark Armitage, Health Sector Workforce and Beneficiary Services
2023 03 09 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Regulation of Clinical Counsellors and Diagnostic and Therapeutic Occupations

Topic: Counselling therapists and diagnostic and therapeutic health occupations seeking to become regulated health professions under the *Health Professions Act* (HPA).

Key Messaging and Recommended Response:

- **Health professional regulation measures are vital for ensuring both health-care workers and patients are supported. We are committed to ensuring ethical, professional, and competent Diagnostic and Therapeutic (D&T) professions throughout BC.**
- **Four D&T professions: respiratory therapists, radiation therapists, clinical perfusionists, and medical laboratory technologists were designated as health professions by Cabinet in 2017.**
    - **The Ministry of Health is currently working with partners to develop the four D&T profession-specific regulations.**
    - **These regulations will come into force following the implementation of the *Health Professions and Occupations Act (HPOA).***
    - **These professions will be regulated by a future amalgamated college of allied health professionals.**
- **In addition, the Ministry of Health is currently gathering information needed to inform a decision by Cabinet about which counselling disciplines will be regulated.**
- **Health care professional regulations help us protect the public during some of their most vulnerable moments accessing health care.**

If asked about the HPOA

- **This legislation is about keeping people safe. That's always been the role of regulatory colleges and that's what this legislation allows us to do better. It takes a proactive approach to eliminating discrimination in BC's health care system.**
- **The HPOA came out of a very significant report conducted by an expert in the field of health profession regulation, Harry Cayton. The report was the result of an inquiry into possible approaches to modernize BC's overall health regulatory framework and an inquiry into the College of Dental Surgeons of BC.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- Four Diagnostic & Therapeutic (D&T) professions (respiratory therapists, radiation therapists, clinical perfusionists and medical laboratory technologists) have been designated and will be regulated by a future amalgamated college of allied health professionals.
- The Minister of Health has also stated his interest in regulating clinical counsellors.
- Work is underway to gather the information necessary to inform a decision by Cabinet respecting which counselling disciplines will be regulated.
- Those counselling disciplines which are designated will be regulated by a future amalgamated college of allied health professionals.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Diagnostics and Therapeutics (D&T)

- Four D&T occupations (respiratory therapists, radiation therapists, clinical perfusionists and medical laboratory technologists) were designated by Cabinet as health professions in 2017.
- The four designated D&T professions were previously slated to be regulated under their own regulatory college however, this work was paused as the Ministry focused on the Cayton Report, the resulting work of the Steering Committee, and the development of the *Health Professions and Occupations Act*.
- Work is underway to develop the D&T profession-specific regulations, which will come into force following the implementation of the *Health Professions and Occupations Act*.

Clinical Counsellors

- A wide variety of counselling disciplines deliver counselling therapy, with diverse competencies, levels of education to enter practice, and preferred treatment modalities.
- Counsellors are not currently regulated in BC.
- Counsellors in BC may be members of associations such as the BC Association of Clinical Counsellors (BCACC) and the Federation of Associations for Counselling Therapists in BC (FACTBC).
- BCACC is a professional association that represents Registered Clinical Counsellors (RCCs) who meet the association's defined educational and competency requirements. By virtue of being a "RCC" with the BCACC, most members can bill private insurance plans for their counselling services.
- FACTBC is a society which represents thirteen counselling associations including those for art therapy, music therapy, family counselling, hypnotherapy, spiritual therapy, Christian counselling, cooperative counselling, and psychotherapy.
- Ministry staff are working with both counselling associations to gather the information necessary to inform a Cabinet decision on which counselling disciplines to regulate.
- Some counselling disciplines in BC may not meet the definition of a health profession.

LAST UPDATED

The content of this fact sheet is current as of February 14, 2023, as confirmed by Mark MacKinnon.

APPROVALS

2023 02 25 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Relational Security Initiative

Topic: Led by the Ministry of Health's Health Sector Health and Safety Unit (HSU), this initiative will implement an in-house relational security model at 26 designated health care settings across the province, through the hiring of 320 Relational Security Officers (RSOs) and 14 Violence Prevention Leads, in addition to a standardized onboarding and training curriculum to embed trauma-informed care and relational security principles.

Key Messaging and Recommended Response:

- **Workplace violence is a serious issue and is more common in health care than in other industries. We know that since the COVID-19 pandemic the risk of incidences of workplace violence has intensified.**
- **Ensuring our health-care facilities are free of violence is a priority for the province.**
- **That is why government is actively taking steps to build safer workplaces for health-care workers by introducing a new security model that will be implemented in 26 sites across all health authorities.**
- **We know that this is an urgent need, which is why we announced funding for this new security model in fall 2022.**
- **This new security model will see 14 Violence Protection Leads and 320 Relational Security Officers (RSOs) provide 24/7 security coverage at the sites mentioned.**
- **Training being developed will ensure all security personnel have an acute awareness of patients and their surroundings, as well as how to anticipate, de-escalate and ultimately prevent aggression. It is based on trauma-informed practice, which integrates knowledge of how people are affected by trauma into procedures, practices and services.**
- **These in-house unionized RSO roles will provide better stability in health care security staffing by providing staff with fair wages, benefits, and career laddering into other health sector roles.**
- **As of January 30, 2023, 11 of the 14 Violence Prevention Lead roles have been filled and hiring for the RSO positions are underway across all health authorities.**

LEGISLATIVE SESSION – ESTIMATES NOTE

- **These actions will help ensure health-care facilities are free of violence and help support, recruit, and retain health-care workers in their vital roles in the health care system.**

CURRENT SITUATION

- Physical and psychological health and safety are key factors to the retention and retainment of the health sector workforce. The goal of this initiative is to support the reduction of workplace violence and psychological injury among the health sector workforce and integrate protection services within a team-based system of care approach.
- The 26 sites for implementation of the relational security model were selected in consultation with the BCNU and health authorities.

Fraser Health	Providence Health	Vancouver Coastal Health	Provincial Health Services Authority	Island Health	Interior Health	Northern Health
• Abbotsford Regional • Burnaby Hospital • Chilliwack General • Delta Hospital • Langley Memorial • Peace Arch • Royal Columbian • Surrey Memorial	• Mount Saint Joseph • St. Paul's Hospital	• Lion's Gate Hospital • Richmond Hospital • Vancouver General Hospital	BC Women's and Children's Hospital	• Cowichan Lodge • Saanich Peninsula Hospital	• Cariboo Memorial • East Kootenay Regional • Kelowna General • Kootenay Boundary Regional • Penticton Regional • Royal Inland • Vernon Jubilee	• Mills Memorial • Prince Rupert Regional • University Hospital of Northern BC

- The 320 RSOs will provide 24/7 security coverage at the identified high-risk sites and be integrated into the health care teams. RSOs will be direct health authority employees, and unionized Hospital Employees' Union positions under the Facilities' Bargaining Association collective agreement. PSOs at Vancouver Island Health Authority (VIHA) are currently a Grid 19 after a recent arbitration decision and have an annual salary (inc. pension and benefits) of $63,446.61. Hiring for the RSO positions is currently underway across all health authorities.
- The RSOs will receive standardized training and onboarding, including an additional customized Trauma Informed Practise Training provided by trained Violence Prevention Leads. Trauma informed practise training will equip RSOs with the necessary skills, language, and knowledge to be able to apply an appropriate and trauma informed lens to interactions with patients, clients, and colleagues.
- To ensure adequate operational and training support for the implementation of the relational security model, 14 permanent Violence Prevention Lead roles are currently posted to increase organizational and human resource capacity with the health authorities. As of January 30, 2023, 11 of the 14 Violence Prevention Lead roles have been filled.
- To ensure consistency in training across RSOs and the rest of the care team, the trauma informed practise principles will be embedded within the Provincial Violence Prevention Curriculum (PVPC), which is mandatory for all health authority staff and is currently undergoing a refresh led by SWITCH BC.
- This initiative aims to reduce incidents of workplace violence, and time-loss and injury claims due to violence. To measure the effect of implementation of the relational security model, an evaluation

framework will be co-created with SWITCH BC, in consultation with the Provincial OHS Council, Provincial Workplace Health Services, OHS Solutions and unions.

FINANCIAL IMPLICATIONS

- In 2022/23, the Ministry provided funding of $352,000 to support the implementation of 14 violence prevention leads and RSOs who will be hired to help create a safer environment for staff and patients.
- PHSA is leading the development of the customized RSO training curriculum. The Ministry is providing $81,000 to PHSA to develop the curriculum, including the initial training of the Violence Prevention Leads.
- Continued funding for the 320 RSOs and 14 Violence Prevention Leads will be provided from the nearly $1 billion over three years provided in Budget 2023 to support the Health Workforce Strategy.

KEY BACKGROUND

- The Marchbank Report prioritized the collaboration between the Ministry's HSU and health authorities to develop, plan and implement the expansion of a provincial integrated security model, with enhanced security functions as part of the broader care team in high-risk units.
- In addition, in 2021, the BC Nurses' Union (BCNU) reiterated workplace health and safety concerns, specifically requesting that Protection Service Officers (PSOs) be staffed 24/7 at sites deemed high-risk for violence.
- This initiative is one of five actions under BC's 2022 Health Human Resources Strategy retention cornerstone, reiterating a commitment to retaining the current health care workforce by ensuring physically and psychologically safe workplaces.
- Since 2002, most provincial health care protection services positions have been privately contracted and provide traditional security functions for the facility, with the exception of VIHA. VIHA's successful in-house Protection Services Officer (PSO) model integrates every PSO in care planning and informing patient treatment plans.
- Protection services were not identified for repatriation under Bill 47 because of the moderate equipment and technology costs, unique training requirements, and staffing models. Implementation of a new protection services model provides an opportunity to create and plan phased implementation of a provincial healthcare protection services framework that incorporates best practices into team-based care and achieves further benefits for workers under continued repatriation of privatized health sector support services, under Bill 47.

LAST UPDATED

The content of this fact sheet is current as of February 14, 2023 as confirmed by Evan Howatson, Executive Director, Labour and Agreements Branch.

APPROVALS

2023 02 22 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 09 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Workplace Violence in Health Care

Topic: The Ministry of Health is working with the Health Employers Association of BC (HEABC), health authorities, health sector unions, Doctors of BC, WorkSafeBC, SWITCH BC and SafeCare BC, to reduce and prevent violence in the health care system.

Key Messaging and Recommended Response:

- **Workplace violence is a serious issue and is more common in health care than in other industries. Ensuring that our health-care facilities are free of violence is a priority for the province.**
- **That is why we took actions to provide supports to all health care workers through the new relational security model currently being implemented across the Province.**
- **We announced this new model Fall 2022 and we are actively working on implementing the actions to ensure that health-care workplaces in the province are free of violence.**
- **Under the new relational security model, the province and health authorities are:**
    - **Hiring 320 new in-house Relational Security officers (RSOs) and 14 violence prevention leads;**
    - **Providing training in relational security principles, trauma-informed practice and violence prevention to these new personnel**
    - **Health authorities are prioritizing high-risk facilities, including emergency departments and mental-health units, for the relational security model implementation.**
- **In addition, SWITCH BC is leading the enhancement and strengthening of the Provincial Violence Prevention Curriculum, which will incorporate the trauma-informed practice principles that are embedded within the relational security model:**
    - **This will ensure all health-care workers and medical staff receive standard education in violence mitigation and de-escalation.**
    - **SWITCH BC will engage with health-care teams to hear their ideas on improving health and safety in their workplaces.**

- **To support health care workers and ensure workplaces are free of violence, we've invested:**
  - **$8.5 million, over three years, to support the establishment of SWITCH BC**
  - **$2 million in additional funding to SWITCH BC to address workplace safety**
- **These actions will help ensure health-care facilities are free of violence and help support, recruit, and retain health-care workers in their vital roles in the health care system.**

CURRENT SITUATION

- Workplace injuries due to violence are on the rise in the health care and social service sector. The industry is seeing a steady increase in days lost and claims costs year over year.
- In 2022 there were 4,670 reported incidents of violence in BC's health authorities, and 773 associated WorkSafe BC time loss claims.[1] BC Emergency Health Services has the highest incident rate of violence with 7.59 incidents per 100 FTE.[2]

Provincial Framework and Policy Directive on Workplace Violence Prevention

In 2017, the Ministry issued a Provincial Violence Prevention Policy Framework and a Policy Directive to improve injury reporting systems, provide more effective violence prevention training, and ensure greater accountability for policies and practices among all public and private health employers. The Ministry is working with health authorities, HEABC, and stakeholders to ensure the key actions established by these instruments are implemented. The Workplace Violence Prevention Policy Directive is currently under review to be refreshed.

The Provincial Violence Prevention Curriculum (PVPC)

- As of February 1, 2023, 79.7% of health authority staff who work in high-risk programs (including mental health and substance use, emergency, and residential care) have completed PVPC training.[3]
- A Physician Violence Prevention curriculum was implemented in June 2019 with 350 medical residents completing the 1.5 hours online and 3.5 hours classroom in the first year. Physicians receive continuing medical education credits upon completion.
- A 3-year project to refresh the content of the PVPC is currently underway, led by SWITCH BC. The refreshed PVPC content is expected to launch in Fall of 2024 and will incorporate a trauma-informed and cultural safety lens to the curriculum. (Please refer to the SWITCH BC's fact sheet for additional details.)

Review of Protection Services in Health Care Settings

- On October 24, 2022[4], the Minister announced the implementation of a new relational security model across all health authorities, hiring more protection services employees and expanding funding to SWITCH BC.
- This initiative will establish an in-house relational security model at 26 designated health care settings across the province, through the hiring of 320 Relational Security Officers (RSOs) and 14 Violence Prevention Leads, in addition to a standardized onboarding and training curriculum to embed trauma-

[1] Data from OHS Solutions, February 1, 2023
[2] Data from OHS Solutions, February 1, 2023
[3] Data from OHS Solutions, February 1, 2023
[4] News Release: 320 protection services officers will support safer workplaces for health-care workers

informed care and relational security principles. Please refer to the Relational Security Initiative fact sheet for additional details.

Priority Sites

- In 2015, the Ministry and the Nurses' Bargaining Association (NBA) committed to safety improvements at four facilities deemed high risk for violence. Violence prevention actions were implemented including environmental modifications, increased staffing levels, upgraded communications systems, and added security.
- In 2016, the Ministry and the NBA expanded these efforts to six additional sites: Mills Memorial Hospital, Royal Columbian Hospital, Royal Jubilee Hospital, East Kootenay Regional Hospital, Powell River General Hospital, and Downtown Eastside Community Health Centre.
- Implementation of the recommendations and the utilization of the six sites funds is currently in progress.
- Sites are in the final stages of seeking extensions, with approved projects scheduled to be completed by March 31, 2023.

FINANCIAL IMPLICATIONS

- In 2015/16, the Ministry and the NBA each committed $1.0 million[5] (total $2 million) to implement violence prevention measures at four high-priority sites (noted above).
- In 2016, the Ministry committed $2.0 million[6] through the NBA agreement, to be matched by the NBA, for the purposes of taking targeted action at six high priority sites (noted above).
- The Ministry has provided $8.5 million over 3 years (2019/20-2021/22) to support the establishment of SWITCH BC.[7] In October 2022, the Ministry announced an additional $2 million in funding to SWITCH BC to address workplace safety.
- The Ministry has committed to funding the 320 RSOs and 14 Violence Prevention Leads as part of the nearly $1 billion over three years Budget 2023 provides to support the Health Workforce Strategy.

KEY BACKGROUND

- A Therapeutic Relational Security (TRS) model was implemented at the Forensic Psychiatric Hospital in Coquitlam in 2018 and was very successful in reducing patient aggression and violence.
- In 2018, Michael Marchbank was commissioned by the Ministry to conduct a review on violence in the health sector. The completed report and recommendations were accepted in early 2019.
- As recommended in Marchbank's report, the Ministry established a new Health Sector Health and Safety Unit in 2019 to work with key partners and stakeholders to lead, monitor, and report on the progress towards reducing violence in the health sector.

LAST UPDATED

The content of this fact sheet is current as of February 9, 2023 as confirmed by Evan Howatson, Executive Director, Labour and Agreements Branch.

APPROVALS

2023 02 25 - Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 09 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[5] BC Nurses Union Website: https://www.bcnu.org/news-and-events/update-magazine/oct2015-mental-health
[6] BC Nurses Union Website: https://www.bcnu.org/news-and-events/update-magazine/oct2015-mental-health
[7] News Release: Reducing injuries for health-care workers focus of new safety organization

LEGISLATIVE SESSION – ESTIMATES NOTE

Access to Abortion Services

Topic: The government of BC is committed to providing safe, effective, and accessible abortion services to the residents of the province, regardless of their income level.

Key Messaging and Recommended Response:

- **In January 2018, BC started providing universal, no-cost access to medical abortions (Mifegymiso). This significantly improved access to abortion for people across BC.**
- **In 2016/17, there were 91 Mifegymiso dispenses; in 2021/22 there were 8,440.**
- **People can access abortion services through abortion clinics and some general practitioners, nurse practitioners, gynecologists, and hospitals. For more information on abortion services close to them, people can refer to the HealthLinkBC website.**
- **Anyone who must travel for abortion services may be eligible for the Ministry of Health's Travel Assistance Program, which helps alleviate the costs of travelling within the province for non-emergency medical specialist services not available in the patient's own community.**
- **We are committed to continuing to provide safe, effective, and accessible abortion services to all British Columbians who need them.**

CURRENT SITUATION

- Abortion is an insured service when determined by a physician that it is medically required for a specific patient on a case-by-case basis. Abortion services are available at many facilities throughout the province.
- Both medical abortions (i.e., use of a medication, such as Mifegymiso, to end a pregnancy) and surgical abortions (surgical procedures provided in clinics or hospitals) are available in the province; various factors determine which is more suitable for a patient, including patient preference. Until the past few years, medical abortions made up a very small proportion of total abortions in BC. (See Figure 1 for related data.)
- Regional health authorities are responsible for planning, managing and delivering publicly funded health care services in their jurisdictions, and are expected to provide reasonable access to abortion services.
- The provision of abortion services may be impacted by operational circumstances. For example, lack of available health human resources can create an access challenge for abortion or any other service.
- Government will continue to work with the health authorities to provide, and expand where appropriate, access to abortion services in BC, while prioritizing the protection of people's privacy.

<u>Impact of Mifegymiso on Access to Abortion Services</u>

- Mifegymiso is a combination of the drugs mifepristone and misoprostol and can be used to terminate pregnancies up to 9 weeks gestation. Since January 2018, when Mifegymiso became available to all British Columbians at no cost, its uptake appears to indicate improved access and choice for patients.

- Between January 15, 2018, and March 31, 2022, 1,331 prescribers (physicians, pharmacists, etc., but excluding naturopaths) prescribed Mifegymiso and 692 pharmacies dispensed it to over 25,800 patients.[1]
- Data for 2016/17 - 2021/22 (Table 1) shows that the number of medical abortions increased, and the number of surgical abortions decreased, since full coverage of Mifegymiso by Pharmacare began.
- Mifegymiso provides significant advantages over a surgical option – it can be provided through telemedicine, dispensed in community pharmacies, taken at home, and is more cost effective.
- By avoiding unnecessary surgery, universal coverage of Mifegymiso has resulted in safer, more accessible abortion services. Removing the cost barrier helps ensure that individuals can access this safe, legal, and available option if they choose. It is important, however, that patients are still able to access surgical abortion services, as medical abortion is not always preferable or medically appropriate.

Table 1: Number of Mifegymiso Dispenses and Surgical Abortions in BC, by Fiscal Year [2] [3]

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Mifegymiso Dispenses	91	1,844	4,922	6,327	8,205	8,440
Surgical Abortions	10,086	9,424	8,281	7,593	5,916	5,892
Total	10,177	11,268	13,203	13,920	14,121	14,332

Northern Health Authority (NHA) – Access Issues

Service gaps in Kitimat and Terrace had been brought to the attention of the Ministry. Surgical abortion services are now available again in Terrace. NHA continues to work to fill vacancies in the northwest region and anticipates recruitment efforts will lead to improvements in access to reproductive health care.

Fraser Health Authority (FHA) – Access Issues

FHA is in the process of developing surgical services within the region; patients are able to access abortion services at Vancouver clinics, if appropriate for their needs. Medical abortions are available in FHA.

US Citizens - Access to Abortion Services in BC

- On June 24, 2022, the US Supreme Court overturned the constitutionally protected right to abortion established under Roe vs. Wade in 1973. Access to abortion has already become restricted or banned in several states. As this continues, some American patients may travel to access abortion care[4].
- People from outside BC can get abortions in the province but individuals not covered by the BC Medical Services Plan (MSP) or another federal/provincial/territorial (FTP) medical services plan must pay for the healthcare services they receive in BC.
- Physicians determine the medical fees charged to a patient who is not a beneficiary of MSP/other FPT plan. Health authorities may also charge such patients a facility fee and/or other fees associated with the service.
- New BC residents who are in the MSP wait period can receive coverage for Mifegymiso.

Protest Activities in BC

- Currently, the main protests in the province regarding abortion services are held twice per year by an organization called “40 Days for Life”, which promotes anti-abortion campaigns world-wide.
- According to the group’s website (www.40daysforlife.com/), the next campaign is scheduled for February 22 - April 2, 2023, with “vigils” in Vancouver (BC Women's Hospital & Health Centre) and Victoria (Victoria General Hospital).

FINANCIAL IMPLICATIONS

N/A

[1] PharmaNet Data, Community & Cross Sector Branch; Health Sector Information, Analytics and Reporting Division, February 6, 2023.
[2] PharmaNet Data, Community & Cross Sector Branch; Health Sector Information, Analytics and Reporting Division, February 6, 2023.
[3] MSP. MSP Fee-For-Service Payment Analysis 2016/2017-2021/2022 fee items 4110, 4111, and 4114, https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_ffs_4_fee_item_detail.pdf., cutoff as of September 30, 2022.
[4] Data on U.S. patients obtaining abortion services in BC is not currently available, but data options are being researched.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

Related Legislation and Regulations to Ensure Access and Safety

- Abortion is an insured service under the Provincial *Medicare Protection Act*, and the Provincial Hospital Insurance Act Regulations.
- The *Access to Abortion Services Act* (the Act) states that all people who use the BC health care system, and who provide services for it, should be treated with courtesy and with respect for their dignity and privacy.
- The Act provides for the establishment of access zones around facilities, doctors' offices, and the homes of doctors and service providers, to ensure the safety of staff and patients. Harassment such as protest, interference and intimidation are prohibited within access zones.
- In addition to those under the Act, access zones for 5 facilities have been established in regulation: a facility operated by the Everywoman's Health Centre Society, a facility operated by the Elizabeth Bagshaw Society, 2 locations at Vancouver General Hospital, and the Vancouver Island Women's Clinic.

LAST UPDATED

The content of this fact sheet is current as of February 3, 2023, as confirmed by Manpreet Khaira.

APPROVALS

2023 02 07 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 02 08 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Autism Assessments

Topic: Publicly funded inter-disciplinary diagnostic assessments of children up to 19 years old for autism spectrum disorder are conducted through the BC Autism Assessment Network (BCAAN). There are significant wait times for these assessments. An assessment is required to access public funding for autism services.

Key Messaging and Recommended Response:

- **While we strive to provide timely assessments for autism spectrum disorder to ensure children diagnosed with autism spectrum disorder receive early intervention and specialized care, we know there are challenges in meeting current demand.**
- **The BC Autism Assessment Network (BCAAN) continues to take steps to increase capacity for autism assessments and has developed alternate strategies to help mitigate increased wait times.**
- **Originally implemented during the pandemic, the Ministry of Child and Family Development is permanently extending virtual assessments for children 3.5 and younger and youth 15 to 18. This model of care was rolled out across the province in Spring/Summer 2022.**
- **BCAAN has 59 Qualified Specialists to complete autism spectrum disorder (ASD) assessments. This is up from 52 Qualified Specialists working in 2017.**
- **BCAAN is working closely with the Northern Health Authority to conduct outreach clinics with the goal of reducing wait times in this region.**
- **Prior to 2018, BCAAN received funding for 1,710 assessments annually. In 2019/20, additional annual funding of $1.18 million was added to the base budget by the Ministry of Health to increase the minimum annual funded assessments to 2,148.**

CURRENT SITUATION

- There has been a continued year-over-year increase in referrals to BCAAN. This has impacted wait times. Wait times have been further impacted by COVID-19 and health human resources challenges.
- Since the early stages of the COVID-19 pandemic, BCAAN's wait list has grown from approximately 4,700 (as of March 31, 2020) to 8,080 (as of January 19, 2023). As of January 19, 2023, the wait time for an autism assessment is 82.9 weeks.

Fiscal Year	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/2023 *(to Jan 19/23)*
New Referrals	3,526	3,808	4,430	4,654	4,259	5,300	4,236
Assessments Completed	2,113	2,104	2,279	2,602	1,927	2,431	1,621
Assessments Funded to Complete	1,710	1,710	2,148	2,148	2,148	2,148	2,148
Wait List Size (Total)	-	-	-	4,700	5,530	6,687	8,080
Median Wait Time (weeks)	32.9	45	56.4	60.6	79	85.7 *(Apr. 2022)*	82.9
% Diagnosed After Assessment	68%	66%	70%	69%	69%	70%	71%

- Average wait-times by health authority as of January 17, 2023; compared to last update on August 16, 2022:

Interior Health	67.1 weeks (up from 65.6)
Fraser Health	111.4 weeks (up from 111)
Vancouver Coastal	104 weeks (down from 106.9)
Vancouver Island	60.7 weeks (up from 58.7)
Northern Health	114.6 weeks (down from 119.6)

- In June 2021, Variety – the Children's Charity publicly announced they would fund private autism assessments to families who apply and qualify. The Provincial Health Services Authority (PHSA)/BCAAN was not consulted prior to this announcement, and because private assessments are not tracked provincially, the volume of private autism assessment being funded by Variety is unknown at this time.

Efforts Underway to Manage and Address Wait Times

- The BCAAN waitlist is monitored and reviewed quarterly to support waitlist cleanup and ensure data integrity. A standardized process has been implemented to review the waitlists in a consistent manner to remove any duplicate referrals. BCAAN also monitors the waitlist for youth aging out to ensure they are prioritized for assessment.
- Following a successful 6-month pilot that began in August 2020, Ministry of Children and Family Development (MCFD) has agreed to continue to accept virtual assessments and diagnosis for children 3½ and younger, and youth aged 15-18 indefinitely. Children between 3½ and 15 years are best suited to in person assessment.
- In June 2021, BCAAN streamlined assessments for children 3½ and younger to assess those who are nonverbal and showing severe signs of autism typical behaviours. The goal is to increase capacity and assess this group of children sooner. This model of care was rolled out across the Province in Spring/Summer 2022.
- BCAAN currently has 59 Qualified Specialists available to complete assessments. This is up from 52 Qualified Specialists working in 2017.
- As part of ongoing waitlist management efforts, BCAAN is working closely with the Northern Health Authority to conduct outreach clinics with the goal of reducing wait times in this region.

FINANCIAL IMPLICATIONS

- The 2022/23 budget for BCAAN is $6.65 million.
- In 2021/22, PHSA spent $6.52 million on assessment and diagnostic services through BCAAN, up from $3.82 million in 2010/11.
- Prior to 2018, BCAAN received funding for 1,710 assessments annually. In 2019/20, additional annual funding of $1.18 million was added to the base budget by the Ministry of Health (MoH) to increase the minimum annual funded assessments to 2,148.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- The prevalence of autism has dramatically increased over the past 15 years globally. The US Center for Disease Control and Prevention found the prevalence rate increased from 1 in 110 children in 2006 to 1 in 44 children in 2018. In Canada, the prevalence rate is 1 in 50 children (2019 Canadian Health Survey on Children and Youth); BC's prevalence rate is in alignment with the Canadian and US data. There is no consensus on the reasons for the rise in prevalence, although increased public awareness and increased public health response to autism globally is likely a significant contributor.
- BCAAN is a provincial program operated by the Sunny Hill Health Centre at BC Children's Hospital, which falls under the umbrella of the PHSA.
- BCAAN continues to have recruitment and retention challenges largely due to the higher fees paid for private assessments versus publicly funded assessments.
- MCFD's current funding model for autism services has put intense pressure on physicians/pediatricians to refer children to BCAAN if they have behavioral or developmental challenges, and on diagnosticians to provide a diagnosis. Under the current model, a diagnosis of autism is required to access funding for services through the MCFD Autism Funding Program.
- The impact of MCFD's pilot Family Connections Centres (FCCs) on the demand for BCAAN assessments remains uncertain, although it is unlikely wait lists will be impacted. MoH continues to work closely with MCFD to monitor this work and the pilot FCC sites once they are operational.
- On December 10, 2018, the Representative for Children and Youth (RCY) released the report, *Alone and Afraid*, which includes recommendations for MoH, MCFD, and the Ministry of Education and Childcare (ECC). MoH is the lead Ministry on recommendation 11 which recommends that MoH take steps to incrementally decrease the wait times to 3 months (12 weeks) for completed assessments of autism and complex behavioural developmental conditions across the province by September 30, 2021.
- In December 2021, MoH provided the RCY with an Action Plan to address recommendations and a letter of progress. In late February 2022, MoH submitted a progress update to the RCY showing 4 of 6 action items completed as progress towards fulfilling recommendation 11. A significant amount of work continues to address this recommendation including a review of the BCAAN program and operations to optimize funding, improve services, and reduce wait times. The RCY has requested an update on progress to address recommendations by February 28, 2023.

LAST UPDATED

The content of this fact sheet is current as of March 1, 2023, as confirmed by Eugene Johnson.

APPROVALS

2023 03 07 – Kristy Anderson, Hospital and Provincial Health Services Division
2023 03 21 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Availability of Sexual Assault Forensic Examinations in Hospital Emergency Departments

Topic: Ensuring survivors of sexual assault who present to emergency departments in BC have access to sexual assault forensic examinations (SAFE).

Key Messaging and Recommended Response:

- **SAFE is currently available in 41 hospitals across health authorities in BC with the majority of the SAFEs being conducted by on-call Sexual Assault Nurse Examiners that travel to the hospital.**
- **The Ministry of Health is finalizing a policy that sets expectations (i.e. access to properly trained forensic examiners and standards for sample collection etc.) for health authorities regarding access to SAFE for those who present to any hospital emergency department.**
- **A guideline is being finalized that sets expectations for providing SAFE that is trauma- and violence-informed and culturally safe and equitable for all survivors.**
- **Health authorities will continue to work with the Ministry of Health to standardize and improve access to forensic examinations in emergency departments across BC.**

CURRENT SITUATION

- A provincial scan of hospitals in 2016 and 2020 showed variability in access to SAFE in BC emergency departments.
- Sexual assault (SA) survivors can receive *medical* care at all BC acute care hospitals but are not currently guaranteed access to *forensic* care examinations at all sites.
- To address these variances, the Ministry of Health (the Ministry) developed policy that sets expectations for health authorities regarding access to SAFE for SA survivors who present to any hospital emergency department and requirements for forensic examiner training across three access models. The SAFE policy is in the final approval stage.
- Advice/Recommentations; Legal Information

- SAFE is currently available in 41 hospitals across health authorities in BC with the majority of the SAFEs being conducted by on-call Sexual Assault Nurse Examiners that travel to the hospital.

FINANCIAL IMPLICATIONS

N/A

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

SAFE in Hospital Emergency Departments

- Access to SAFE for survivors who present to hospital emergency departments is only one element of an overarching response to SA.
- A SAFE is a set of medical-legal processes that include the collection of biological material, recording of relevant patient history, and/or documentation of the effects of sexual assault which may be used as evidence in a court of law.
- Forensic care is focused on the collection of samples to support a criminal justice response to the assault. Properly trained forensic examiners help ensure a survivor who decides to report the assault has the best chance of a positive criminal justice outcome.
- Samples collected during a SAFE and examiner testimony can be critical to the successful prosecution of those who perpetrate the crime of sexual assault.

SAFE Policy and Guidelines

Advice/Recommentations

Table 1: *SAFE Sites (As of January 27, 2023)*[1]

Health Authority	Number of hospitals providing SAFEs (includes mobile services)
Interior Health Authority	8
Fraser Health Authority	2
Vancouver Coastal Health Authority	9
Island Health Authority	13
Northern Health Authority	8
Provincial Health Services Authority	1
Total Number of Sites	41

Action Plan to End Gender-Based Violence

- The Parliamentary Secretary for Gender Equity and the Minister of Public Safety and Solicitor General share a mandate commitment to develop an action plan to end gender-based violence (GBV), including minimum standards for sexual assault response, more training for police, Crown counsel and justices, and establishing core funding for sexual assault centres.
- Governance for the development of the GBV Action Plan includes an ADM-level Steering Committee (SC) and a Director-level Working Group (WG). Representatives from Population and Public Health (PPH), Hospital and Provincial Health Services (HPHS), and the Associate Deputy Minister's Office on Indigenous Health (ADMIH) sit on the SC and WG to ensure alignment of Ministry work on GBV and SA with the broader Provincial GBV Action Plan.

Advice/Recommentations; Intergovernmental Communications

[1] Site numbers provided by each health authority on January 27, 2023.

- The implementation of the SAFE policy and guideline is only deliverable in the broader cross program GBV Action Plan that HPHS has accountability and oversight for.

LAST UPDATED

The content of this fact sheet is current as of February 2, 2023 as confirmed by Manpreet Khaira

APPROVALS

2023 02 08 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

BC 10-Year Cancer Action Plan

Topic: The Ministry of Health has a mandate to "make BC a leader in the full continuum of cancer care by launching a 10-year cancer action plan and identify near-term opportunities to improve services."

Key Messaging and Recommended Response:

- **Any wait is too long for someone with cancer.**
- **That's why in 2020 we promised British Columbians a new 10-year Provincial Cancer Action Plan, which we have now delivered.**
- **Our initial nearly half-a-billion-dollar ($440 million) investment will:**
  - **expand cancer care teams and service hours,**
  - **introduce revised pay structures to ensure BC is attractive and competitive for oncologists and cancer care professionals,**
  - **improve cancer screening programs,**
  - **increase Indigenous patient support positions,**
  - **support cancer research and attract the skilled cancer care providers needed to provide specialized treatments; and**
  - **add new funding to support people living in rural and remote communities who need to travel for cancer care.**
- **Since 2017, we have invested over $1 billion to support the creation of a strong and sustainable cancer care system.**
- **These are the most significant investments in cancer care in the province's history and we know it is required to meet the growing demand for cancer services as people age.**
- **We are committed to strengthening equity of access to cancer care and cancer surgery services to ensure that people living in BC have the best cancer care possible.**

CURRENT SITUATION

- On February 24, 2023, the provincial government launched BC's 10-Year Cancer Action Plan (the Plan), including an initial investment of $440 million, including operating funding of $270 million over 3 years to BC Cancer, a one-time grant of $150 million grant to the BC Cancer Foundation in 2022/23, and $20 million in one-time grants in 2022/23 to support patient travel.

- The Plan includes immediate steps to better prevent, detect and treat cancers, and deliver improved care for people now while preparing for the growing needs of the future.
- The $270 million over 3 years to BC Cancer ($90 million per year starting in 2023/24) will support foundational work including:
    - Operationalizing team-based care across all BC Cancer Centres to stabilize and enhance the cancer workforce and build treatment capacity – progress as of March 2023 per BC Cancer reporting:
        - Vancouver: 33 out of 33 teams activated (100%)
        - Abbotsford: 4 out of 5 teams activated (80%)
        - Kelowna: 8 out of 11 teams activated (73%)
        - Prince George: 3 out of 7 teams activated (43%)
        - Victoria: 2 out of 5 teams activated (40%)
        - Surrey: 1 out of 7 teams activated (14%)
        - Overall: 51 out of 68 teams activated (75%)
    - Expanding hours of operation for systemic (chemo) therapy – progress as of March 2023:
        - Extended operating hours for systemic therapy is planned for Abbotsford, Kelowna, Surrey, Victoria and Vancouver.
        - BC Cancer is finalizing coverage agreement with physicians.
        - Once finalized, physician scheduling and master rotation changes work will be done.
    - Expanding access to imaging to speed up diagnosis (PET/CT, CT, breast imaging) – progress as of March 2023:
        - Kelowna, Vancouver and Victoria will expand physician contracts to read additional PET scans.
        - Additional 25 scans per day read in Kelowna and Victoria – a doubling of capacity.
        - As of March 10, Kelowna and Victoria have confirmed contracts, Vancouver is pending.
        - Mitigation strategies are underway to reduce breast imaging wait times at the Vancouver Cancer Centre and BC Women's Hospital (BCWH).
        - Vancouver added 13 additional biopsy days from Jan-March 2023 resulting in ~33 more stereo core biopsies plus 6 contrast enhanced mammography cases.
        - BCWH has reduced referral backlog from ~8 months to ~4 months.
    - Addressing the recruitment and retention of oncologists and general practitioner oncologists – progress as of April 2023
        - A new compensation model for oncologists is taking effect to place BC oncologists within the top third nationally.
    - Expanding indigenous patient support positions – progress as if March 2023:
        - There are 6 positions in place – one at each regional cancer centre. An additional position is being recruited in Kelowna to meet demand there.
    - Improving cancer screening programs and continued expansion of the Hereditary Cancer Program.
- The one-time $150 million grant in 2022/23 to the BC Cancer Foundation will support cancer research and attract the skilled cancer-care providers needed to provide specialized treatments including:
    - Delivering clinical trials across all cancer centres in the province, allowing for greater access for patients living outside of large city centres to participate in clinical trials.
    - Increasing radiation oncology trials that study treatment approaches, and precision radiotherapy research to enhance efficacy while reducing toxicity from radiation treatments.
    - Enhancing capacity in genomic testing to deliver optimal treatment for every patient.
    - Expanding access to new diagnostic and therapeutic approaches, treatments, and technologies, and establishing innovative cancer treatment programs.
    - Supporting emerging multi-disciplinary research programs.
    - Enhancing capacity in population health and health economics research.
    - Providing research start-up and seed grants to attract research talent.
    - Creating four endowed leadership and research chairs within the foundation to help recruit and retain key clinical researchers that are vital to the long-term success of BC Cancer.

  - Creating scholarships within the foundation to support schooling for critical cancer medical positions, such as radiation therapists and technologists (particularly in radiotherapy and PET/CT scans), and medical physicists.
- Advice/Recommentations; Government Financial Information

- During development of the Plan, the province continued to move forward with strategic investments to address the growing demand for cancer care services in BC, address wait times, and build the capacity and strong foundation required to fulfill the Plan.
  - In 2021/22 and 2022/23, BC Cancer received targeted investments to address workload pressures and to implement a team-based care model, including a $25 million base funding lift in 2021/22 and a $41 million lift in 2022/23.
    - According to BC Cancer, through these initiatives, 399.05 FTEs are being recruited.
    - As of January 31, 2023, BC Cancer has been able to hire a total of 327.45 FTE positions.
    - 73% of physician roles have been hired (51.15 out of 70.25 FTE).
    - 84% of clinical support roles have been hired (276.3 out of 328.8).
    - As of January 31, 2023, BC Cancer has hired 31.85 FTE of 41.85 FTE medical and radiation oncologists (oncologists are counted in physician roles).
    - The hiring includes a mix of clinical support professionals such as nurses, pharmacists, and counsellors; support staff; and physicians, including oncologists, general practitioner oncologists (GPOs) and specialists.
- The Ministry's capital plan seeks to increase the number of cancer centres from 6 to 10, including:
  - The New Surrey Hospital and BC Cancer Centre project is currently in procurement, with approval of preferred proponent scheduled for end of June 2023.
  - Business planning for Burnaby Hospital Phase 2 and a new BC Cancer Centre is underway.
  - Planning is underway for a new cancer centre in Nanaimo and a new cancer centre in Kamloops. The planning is being led by BC Cancer, which is part of the Provincial Health Services Authority (PHSA), in collaboration with Island Health Authority and Interior Health Authority. The Business Plans are expected to be finalized in the fall of 2023. The detailed scope, schedule, budget, and procurement strategy will be confirmed in the Business Plans and announced after Government approval of the Business Plan.

FINANCIAL IMPLICATIONS

BC Cancer annual expenditures have risen from $713.6 million in 2016/17 to $973.1 million in 2021/22. In addition, the BC Cancer drug expenditures (net of rebates) rose from $250.9 million in 2016/17 to $382.8 million in 2021/22.

KEY BACKGROUND

- BC Cancer operates 6 regional cancer centres providing assessment and diagnostic services, systemic therapy (chemotherapy), radiation therapy, and supportive care. The 6 centres are in Abbotsford, Kelowna, Prince George, Surrey, Vancouver, and Victoria.
- Cancer surgery is not done within BC Cancer centres, although the Vancouver Centre does some minor procedures such as biopsies. Patients who require surgery as part of their treatment plan are referred to a hospital in their health authority.
- Expanded cancer care services are also available through BC's 39 comprehensive Community Oncology Networks (CONs) and 2 satellite CONs. The CONs are a collaborative voluntary partnership between hospitals, health authorities and the BC Cancer regional centres. The CONs provide systemic therapy (chemo/hormone/immune therapy) to patients closer to home.
- BC Cancer operates four province-wide screening programs to help identify cancer in its earliest stages, allowing for more treatment options and a better chance of recovery. Screening programs exist for breast, cervical, colon, and lung cancer (launched May 2022). Screening services also exist for British Columbians

who may have an increased risk for specific types of cancer through BC Cancer's Hereditary Cancer Program. This program provides genetic counselling and genetic testing to eligible patients.

- Cancer drugs and supplies are funded through the PHSA's Life Support Budget. A range of life support services are funded through this budget which also include medication and supplies for renal dialysis, organ transplantation, and cardiac services. Oncology accounts for almost 50% of the annual Life Support expenditures ($402 million of the total $779 million Life Support expenditures were for Oncology in 2021/22).
- Currently BC uses 4 internationally recognized benchmarks for access to consults and treatments to measure the cancer system. We are also able to measure the length of time people are waiting to get screened which is critical because early detection. For radiation or medical oncology consult and radiation therapy the benchmark is 90% of patients treated/seen within 4 weeks (28 days). Chemotherapy benchmark is 90% of patients treated within 2 weeks. Generally, performance against wait-time benchmarks has deteriorated across all key benchmarks. Wait-time performance for both medical and radiation oncology consults have failed to meet international benchmarks over the past 5 years and have shown rapid decline in 2022.

Key Performance Benchmarks-Measures represent the % treated /seen within benchmark wait-time.

Priority Procedures and Benchmark	Target	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23 (Q3)
IV Chemotherapy Treatments (2 weeks)	**90**	95	91	82	84	80	79
Radiation Therapy Treatments (4 weeks)	**90**	92	90	91	91	87	83
Radiation oncology consult (4 weeks)	**90**	63	60	54	66	56	46
Medical oncology consult (4 weeks)	**90**	77	73	69	71	61	54

BC Cancer Data and Analytics

- Seven Indigenous patient support roles have been created at all 6 of the BC Cancer regional centres (2 in Kelowna to meet demand) to help patients receiving cancer care who identify as First Nations, Métis, or Inuit. Known as an Indigenous Patient Navigator, the roles provide support and advocacy for Indigenous patients by facilitating and coordinating access to health care services, addressing cultural and spiritual needs, and networking with Indigenous and non-Indigenous health system and community partners.

LAST UPDATED

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APPROVALS

2023 04 11 – Kristy Anderson, Hospital and Provincial Health Services Division
2023 04 17 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

BC Emergency Health Services – General

Topic: BC Emergency Health Services (BCEHS) is part of the Provincial Health Services Authority and coordinates emergency health services to more than 5 million[1] British Columbians across the province and governs emergency health services provided by first responders to British Columbians.

Key Messaging and Recommended Response:

- **There's no question our paramedics, emergency medical call-takers and dispatchers have been working tirelessly over the last 3 years – challenged by the COVID-19 pandemic and the toxic drug supply public health emergency.**
- **Since 2017, we've seen a significant increase in 911 calls. Our government has been working hard – and has made significant progress – to ensure that when British Columbians need immediate medical care and call 911, help is quickly on its way.**
- **We're moving towards a more reliable ambulance service. These changes won't happen overnight, but the investments we've made will retain and recruit more paramedics and dispatch staff, which will provide a more efficient service.**
- **As of February 2023, BCEHS has 75% of its regular permanent full-time and part-time positions filled and is recruiting the remaining 25% vacant positions throughout the province.**
- **And in February 2023, BCEHS and the Ambulance Paramedics of BC announced they had ratified a new collective agreement, supporting approximately 5,000 paramedics and emergency medical call-takers and dispatchers throughout the province.**
- **We also converted 24 rural ambulance stations to 24/7 ALPHA stations, meaning better, quicker ambulance services for British Columbians and more predictable work and better pay for paramedics.**
- **So, as you can see, we're making significant improvements and investments to BCEHS. And while there is much work left to do, we're on the right track.**

[1] B.C. government population estimates 2021

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- BCEHS paramedics respond to more than half a million medical emergency 911 calls a year and transfer more than 70,000 patients a year between facilities (usually hospitals).
- In 2021 BCEHS added 539 permanent regular full-time paramedic positions, 71 permanent irregular full-time positions, and 42 full-time dispatch positions.
- In November 2022, BCEHS added 222 permanent new full-time regular paramedic positions.
- Additionally, in December 2022, BCEHS announced 190 permanent full-time primary care paramedic and emergency medical responder positions that will be added to the system in early 2023. This includes 152 regular full-time positions and 38 irregular full-time positions (irregular positions cover for leaves, vacations, illness, etc.).
- A national recruitment campaign is underway to hire paramedics/dispatchers to fill vacancies.
- In 2021, 249 paramedics successfully went through new employee orientation (NEO), and in 2022, 522 paramedics successfully went through NEO.
- In March 2022, the Provincial Health Services Authority supported the creation of a dedicated talent acquisition team within BCEHS, which has more than doubled in size, from 8.8 permanent positions to 21 permanent positions. There is also a more robust dedicated talent acquisition structure within BCEHS, with a dedicated manager and director.
- As of February 3, 2023, BCEHS has 2,643 permanent regular part-time and full-time positions. Of those positions 1,975 (75%) are filled. Recruitment efforts for vacant positions continue in regions throughout BC.
- Since 2020, BCEHS added 77 ground ambulances and 5 air ambulances. 55 new ground ambulances and 5 air ambulances were added as part of the Rural, Remote, First Nations and Indigenous COVID-19 Response Framework. 22 new ambulances announced in 2021, were deployed over 2021/22 to support patient care.
- A new 3-year agreement (April 1, 2022, to March 31, 2025) between the Ambulance Paramedics and Ambulance Dispatchers Bargaining Association and the Health Employers Association BC was reached on January 6, 2023, with ratification announced on February 15, 2023. The ratified agreement includes general wage increases:
    - Year 1 - a flat increase of $0.25 per hour, which provides a greater percentage increase for lower-paid employees, plus a wage increase of 3.24%
    - Year 2 - 5.5% plus a potential cost-of-living adjustment to a maximum of 6.75%
    - Year 3 - 2% plus a potential cost-of-living adjustment to a maximum of 3%

System Performance/Impacts

- BCEHS responds to the most critically ill and injured patients first, based on a medical priority dispatch system used around the world. Patients reported to have life-threatening symptoms -- cardiac arrest, chest pain, breathing difficulties, and severe bleeding or unconsciousness -- are prioritized.
- BCEHS meets its provincial target of under 9 minutes to respond to the most life-threatening category of calls (Purple calls) in urban and rural communities.
- 40% of the average 1,500 911 calls BCEHS responds to every day are lower acuity (e.g., require care for cuts, wounds, sprains, muscle strains, mild illness, or skin conditions). Some of these patients do not require a trip to an emergency department, but they require some form of connection to care.
- Secondary tirage primary care paramedics were added in early 2022 to manage less-urgent calls to help reserve ambulances for emergencies. The secondary triage desk is supported by paramedic specialists, senior dispatchers and a patient navigator for patients who may not need transport to hospital.
- In 2021, BCEHS improved its contingency/escalation process (Clinical Safety Plan) to maintain patient and staff safety through spikes in demand. The Clinical Safety Plan helps reduce turnaround times at hospitals, delays non-urgent transfers, and increases secondary triage/alternate care and transport options, so ambulances are available for life-threatening 911 calls.
- In 2021 BCEHS introduced alternate transport methods that provides 12 new “low-acuity response units” to transport patients with non-urgent conditions to health care centres – 6 units are in the Fraser Health, 4 are in Interior Health and 2 are in Island Health.

Mental Health

- In 2021 stress-related injuries accounted for 30% of all BCEHS time-loss claims (218 claims).
- In 2022, more than 350 Critical Incident Stress incidents have been reported, with more than 20 percent associated with time loss. Finalized, adjudicated WorkSafeBC claim stats are being reconciled.
- On December 3, 2021, an announcement by the Minister of Health called for immediate actions to support the wellness of BC's front-line staff.
- As part of the immediate actions BCEHS continues to undertake an expansion of the Critical Incident Stress Management (CISM) program by adding resources to the network of trauma-informed and occupationally competent therapists and counsellors who provide psychological care (in total, 257 professionals are in this network). Work includes developing educational resources in psychological safety, workplace mental health, and resilience.
- BCEHS is working with KPMG to evaluate the CISM program and support for staff, with analysis aimed at aiding in future planning and next steps.

FINANCIAL IMPLICATIONS

- Since 2017, BCEHS' annual spending has increased from $424.25 million to $634.49 million.
- Budget 2023 provides $130 million over three years to support an increase to the on-call rate for paramedics that will expand ambulance coverage throughout BC.

KEY BACKGROUND

- Since 2021, the Ministry of Health provided BCEHS with significant investment funding for increased paramedic/dispatch staffing to improve ambulance service and includes converting on-call/casual positions to regularly scheduled full- and part-time positions.
- In July 2021, the Minister announced 22 rural community ambulance stations (since increased to 24) to 24/7 ALPHA and hiring an additional 177 full time paramedic positions. This was complete in October 2021.
- Regulatory changes approved in September 2022 will permit first responders and paramedics to provide better pre-hospital care on-scene once the appropriate training and licensing are in place.
- On February 2, 2023, the government announced $2 million to expand paramedic training programs in communities around the province.

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APPROVALS

2023 03 21 – Kristy Anderson, Hospital and Provincial Health Services Division
2023 03 24 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 03 27 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Dense Breast and Supplementary Imaging

Topic: Access issues to supplemental breast ultrasound screening for individuals with dense breasts. Advocacy group 'Dense Breasts Canada' has advocated for supplemental imaging for these individuals.

Key Messaging and Recommended Response:

- **Early detection of cancer is critical to increasing the number of people cured and reducing the impact of cancer on the population.**
- **BC was the first province in Canada to provide breast density scores to individuals and their providers in 2018.**
- **As of December 2018, BC has publicly funded supplemental screening, as an adjunct to mammography, for people with extremely dense breasts when clinically indicated.**
- **Mammography remains the recommended imaging modality for breast cancer screening.**
- **Some individuals with dense breasts may benefit from a supplementary ultrasound to find possible cancerous tumours with a negative mammogram result.**
- **However, there is not enough evidence to include supplemental breast screening ultrasound for individuals with dense breast tissue as a sole risk factor into a population-based screening program.**
- **The Canadian Task Force on Preventive Health Care and the US Preventive Services Task Force do not recommend supplemental breast ultrasound screening based on dense breast tissue alone.**

CURRENT SITUATION

- Dense Breasts Canada has advocated for all individuals who have dense breasts following a screening mammogram (asymptomatic) to have supplementary testing with a screening breast ultrasound.
- Supplemental screening breast ultrasound is an insured medical benefit when requested by a primary care provider for individuals with dense breasts if they feel further investigation is needed. This change was made to Medical Services Plan (MSP) in December 2018, after BC became the first province in Canada to provide breast density scores to individuals and their primary care provider from screening mammograms in October 2018.

- There are known access and wait time issues with screening and non-emergency diagnostic ultrasounds due to:
  1) A shortage of all types of sonographers, including those who perform breast imaging exams that require further specialization beyond what regular sonographer certification programs offer.[1]
  2) A limited number of facilities offering breast screening ultrasounds.
- To support further guidance on supplemental screening and access, the Ministry of Health (the Ministry), through the Medical Imaging Advisory Committee initiated a Breast Imaging Services Project in 2021.
- Clinical consensus on which patients should receive supplemental breast ultrasound screening was not reached on this project.
- The Ministry is:
  1) Closely monitoring other research that is underway, that will help guide best practices for this patient group:
     - a Health Technology Assessment on the value of the different imaging modalities for supplemental testing from Ontario (expected publish date Spring 2023)[2]; and
     - the Japan Strategic Anti-Cancer Randomized Trial, examining the impact of supplemental ultrasound screening in detecting early breast cancers.
     - emerging technologies, such as the use of contrast-enhanced mammography.
  2) Actively looking at building capacity by increasing the number technologists with the required specialized breast ultrasound training. BCIT is building a breast sonography curriculum, with the theory component already in action. Clinical component is still under development.

FINANCIAL IMPLICATIONS

An increase in screening breast ultrasounds would have an impact on MSP budgets. The amount is unknown at this time as the number of breast ultrasounds performed due to dense breasts is unknown.

KEY BACKGROUND

Breast Density Scores

- Breast density is measured by comparing the amount of fibrous and glandular (dense) to fatty (non-dense) tissue within the breast when a radiologist is assessing a mammogram.
- It is scored by a radiologist on a 4-point letter scale, with the C and D scoring categorized as dense breasts.
- Having dense breasts can have 2 effects:
  1) An increased cancer risk, though breast density is one factor amongst many other well-established risk factors including: sex, age, family history, genetic mutations (e.g., BRCA-1), 2
  2) A reduced ability to detect abnormalities by mammography due to a masking effect of dense tissue.
- In 2019, 34% of participants in BC Cancer's Breast Screening Program scored a C, and 7% a D in breast density. This equates to approximately 109,226 individuals with dense breasts in the BC screening program.[3]
- On October 1, 2018, BC became the first province in Canada to provide breast density assessments to patients and their primary care providers following screening mammogram. Other provinces have started reporting since that time.
- In 2021/22, there were 101,044 unilateral breast ultrasounds performed, and 17,793 of those were bilateral exams.[4] With the addition of supplemental screening ultrasounds as an insured service, and if the 100,000+ patients with a C and D score requested supplementary ultrasound testing, it could result in an increase of 600% from current bilateral ultrasound volumes.

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[1] FACT SHEET: Diagnostic Medical Sonography.
[2] A draft report was released for public external review, which recommends recommends publicly funding supplemental screening as an adjunct to mammography for people with extremely dense breasts.
[3] BC Cancer, BIRADS % Distribution from Discussion Guide: Breast Density, January 2021, page 1, link: http://www.bccancer.bc.ca/screening/Documents/Breast-Density-Discussion-Guide.pdf and Program Participants from BC Cancer Breast Screening 2019 Program Results, September 2020, page 16, link: http://www.bccancer.bc.ca/screening/Documents/Breast-Screening-Program-Report-2019.pdf
[4] MSP Database for 2021/22 for Fee Items #86047 (Breast Sonogram – unilateral) and #86048 (Breast Sonogram – additional side), https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_ffs_payment_analysis_20172018_to_20212022.pdf

Supplementary Imaging for Individuals with Dense Breasts

- Mammography remains the recommended imaging modality for breast cancer screening.
- Some individuals with dense breasts may benefit from a supplementary ultrasound to find possible cancerous tumours with a negative mammogram result.
- There is not enough evidence to include supplemental breast screening ultrasound for individuals with dense breast tissue as a sole risk factor into a population-based screening program. The Canadian Task Force on Preventive Health Care and the US Preventive Services Task Force do not recommend supplemental breast ultrasound screening based on dense breast tissue alone.

Breast Imaging Wait Times

The Ministry does not collect ultrasound wait times for data analysis and reporting from health authorities or community imaging clinics.

LAST UPDATED

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APPROVALS

2023 04 08 – Kristy Anderson, Hospital & Provincial Health Services Division
2023 04 13 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Diagnostic Imaging Strategy

Topic: Update on the diagnostic imaging strategy focused on access to Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) exams.

Key Messaging and Recommended Response:

- **Since 2016/17, new units have been added across the province not only increasing capacity but geographic access, including 17 net-new MRI units and six CT units.**
- **As a result, the province has made tremendous progress on reducing wait-times for diagnostic imaging:**
    - **For MRI wait times in the 90th percentile of the population, we went from 3rd in the country in 2019 to 1st in 2022, according to the Canadian Institute for Health Information (CIHI).**
- **As well as increasing overall diagnostic imaging capacity:**
    - **+69% more MRI exams per year since 2016/17**
    - **+32% more CT exams per year since 2016/17**

CURRENT SITUATION

- In the Budget 2023 speech, the government renewed its commitment to enhance access to diagnostic imaging.
- Enhanced access to MRI and CT exams is supported by 4 key strategies: 1) building further capacity; 2) increasing essential personnel; 3) optimizing business processes; and 4) improving waitlist management and reporting.
- Since 2016/17:
    - over 297,000 MRI exams are performed each year , an increase of over 121,000 (+69%) exams.
    - over 920,000 CT exams are performed each year, an increase of over 228,000 (+33%) exams.
- Shortages of technologists continue to impact maintenance and limit expansion of operating hours for MRI and CT services. In April 2022, BC Institute of Technology launched the MRI Bursary Program to increase the supply of new imaging technologist graduates by providing financial aid to complete their studies sooner. Over 3 terms, 34 students have taken advantage of the opportunity to complete their MRI training in an accelerated timeframe.
- Work is underway to modernize MRI ordering with electronic tools that will reduce wait times by reducing delays caused by rejected requisitions and providing patients and referring practitioners with transparent waitlist information to inform site selection.

FINANCIAL IMPLICATIONS

In both 2021/22 and 2022/23 the Ministry allocated base funding of $42.16 million in targeted funding to support to support medical imaging activities in the health authorities.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

NOTE: All 2022/23 data is based on Period 12 submissions or Period 13 estimations and are subject to change post-audit.

Magnetic Resonance Imaging (MRI)

Volumes

- In 2022/23, over 297,000 MRI exams were completed. This equates to 55.9 exams per 1,000 population, compared to the national rate of 61.7.
- Compared to 2016/17, the number of exams has increased by over 121,000 (or +69%) in 2022/23.

MRI	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23**	Change: 2016/17 to 2022/23	
								#	%
Volumes	175,707	189,520	233,368	252,527	247,106	296,408	297,253	+121,546 exams	+69%

** For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
*** Based on Year End Estimations / Projections.*

Wait Times[1]

- In 2022/23, 90% of patients received their MRI exams within 143 days, and 50% waited 53 days or less.
- Compared to 2016/17, wait times in 2022/23 decreased by 130 days (or -48%) for the 90th percentile.

MRI	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23**	Change: 2016/17 to 2022/23	
								#	%
50th	55	47	39	47	56	43	53	-2 days	-4%
90th	273	210	196	148	188	128	143	- 130 days	-48%

**NOTE: For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
*** Based on Period 12 Year-to-Date.*

Operating Hours[2]

- In 2022/32, MRI units operated on average over 4,500 hours per week.
- Compared to August 2017, average operating hours per week in 2022/23 increased by over 1,700 (or +64%).

MRI	2016/17	2017/18*	2018/19	2019/20	2020/21**	2021/22	2022/23***	Change: 2017/18 to 2022/23	
								#	%
Hours	n/a	2,766	3,692	3,997	4,343	4,631	4,542	+1,777 hours/week	+64%

**2017/18 is a snapshot week as of August 2017.*
*** For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
**** Based on Period 12 Year-to-Date average.*

Equipment Inventory

- Since 2017, the number of MRI scanners in BC has increased from 25 to 42, an increase of 17 scanners or an increase 147%.
- This equates to 8.1 units per 1,000,000 population, compared to the national rate of 10.0.

Computed Tomography (CT)

Volumes

- In 2022/23, over 923,000 CT exams were completed. This equates to 173.7.8 exams per 1,000 population, compared to the national rate of 143.4.
- Compared to 2016/17, the number of exams has increased by over 228,000 (or +32%) in 2022/23.

CT	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23**	Change: 2016/17 to 2022/23	
								#	%
Volumes	695,248	733,787	788,439	805,584	812,213	901,296	923,352	+228,104 exams	+32%

**For the first 6 weeks of 2020/21, non-urgent MRI exams were postponed due to the COVID-19 pandemic.*
*** Based on Year End Estimations / Projections.*

[1] Health Sector Information, Analysis and Reporting (HSIAR) Division. Medical Imaging Wait Times Standard Report P12 and P13 2021/22 RMS 2380

[2] Operating Hours: MRI Weekly Operating Hours: Manual submissions by Heath Authorities.

Wait Times[3]

- In 2022/23, 90% of patients received their CT exams within 142 days, and 50% waited 23 days or less.
- Compared to 2016/17, wait times have increased by 52 days (or +58%) for 90th percentile in 2022/23.

CT	2016/17	2017/18	2018/19	2019/20	2020/21*	2021/22	2022/23**	Change: 2016/17 to 2022/23	
								#	%
50th	21	23	22	22	22	22	23	+ 2days	+10%
90th	90	95	95	106	143	101	142	+52 days	+58%

**For the first 6 weeks of 2020/21, non-urgent CT exams were postponed due to the COVID-19 pandemic.*
*** Based on Period 12 Year-to-Date.*

Equipment Inventory

- Since 2017, the number of CT scanners in BC has increased from 63 to 69, an increase of 6 scanners or an increase of 10%.
- This equates to 13.1 units per 1,000,000 population, compared to the national rate of 14.5.

LAST UPDATED

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APPROVALS

2023 02 13 – Kristy Anderson, Hospital and Provincial Health Services Division
2023 02 22 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 10 – Peter Klotz obo Rob Byers, Finance and Corporate Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Emergency Department Access

Topic: Access to timely acute care emergency services is important to both patients and health care providers.

Key Messaging and Recommended Response:

- **The health care worker shortage has created staffing challenges throughout BC, nationally and internationally.**
- **At times, this has resulted in Emergency Department diversions, when adequate staffing is not available to ensure safe patient care.**
- **The decision to divert patients is never made lightly and is only done as a last resort. Health authorities look at all options prior to implementing diversions. This includes looking to move staff between sites as able/needed.**
- **Staffing pressures are often amplified at rural sites where staffing pools are typically smaller.**
- **When a hospital or department is under diversion, patients are sent to other available sites within the region. Every effort is made to divert patients to the closest hospital.**
- **BC's Health Human Resources Strategy includes 70 concrete actions to address staffing capacity issues. The Ministry of Health has already started implementing these actions in 2022/23 and is working closely with several health authorities to ensure adequate access to rural emergency departments.**
- **Recruitment efforts, particularly in rural and remote communities, include incentives such as relocation assistance, rural retention grant and BC loan forgiveness.**

CURRENT SITUATION

- Since the emergence of the COVID-19 pandemic in March 2020, BC has experienced successive waves of COVID-19, with each wave putting additional pressures on the health system. Emergency departments (EDs) are faced with an increasing volume of patients, staffing shortages and staff burnout.
- While ED visits dropped significantly in 2020/21 with the onset of the COVID-19 pandemic and public health orders, during the current fiscal year the number of ED visits has returned to its pre-pandemic growth trend.
- Current ED wait times are impacted by increased ED visits, increased overall hospital occupancy rates, more hospital beds occupied by patients with an Alternative Level of Care (i.e., patients who do not require the intensity of services provided in that care setting) and staffing challenges across the entire acute care and community health sector (see Alternate Level of Care and Hospital Capacity Fact Sheet).

- Staffing challenges and extraordinary climate events have meant some EDs have had to go on diversion to ensure safe care.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Emergency Department Visit Volumes

- Between 2016/17 and 2019/20, prior to the COVID19 pandemic, the average annual growth rate for provincial ED visits was 1.6%.
- In 2020/21, with the onset of the COVID-19 pandemic, ED visits dropped significantly. Province-wide, the number of ED visits decreased by 12.4% compared to 2019/20.
- During the last fiscal year, 2021/22, the number of ED visits has returned to its pre-pandemic growth trend, with the provincial daily average number of ED visits increasing by 2.3% compared to 2019/20.

Daily Average ED Visits 2018/19 to 2022/23							
HA	Pre-COVID		During COVID		Post COVID	Change 2019/20-2020/21	Change 2019/20-2021/22
	2018/19	2019/20	2020/21	2021/22	2022/23 (Latest data to Jan 5, 2023)		
IHA	1,382	1,423	1,443	1635	1833	1.4%	14.9%
FHA	1,925	1,919	1,606	1897	2006	-16.3%	-1.1%
VCHA	1,192	1,178	986	1195	1246	-16.3%	1.5%
VIHA	1,138	1,210	1,072	1237	1325	-11.4%	2.2%
NHA	747	744	593	670	743	-20.3%	-10.0%
PHSA	131	126	83	121	92*	-34.4%	-4.1%
BC	**6,514**	**6,600**	**5,783**	**6755**	**7246**	**-12.4%**	**2.3%**

Data source: HAMIS, 2022/23 – Period 10 – ED Visits
**Due to ongoing technical issues ED data reported by PHSA is placeholder data and not an accurate reflection of ED activity within the Health Authority*

Emergency Department Diversions

- Temporary diversions occur periodically in all health authorities when there is a gap in service at one facility that can be filled using BC's extensive network of hospitals and health care services.
- COVID-19 has put immense strain on BC's health care system and has created particular staffing challenges, which at times may result in a diversion. These pressures are often amplified at rural sites where staffing pools are typically smaller.
- While diversions are never ideal, they are sometimes necessary to ensure the best and safest care is provided to patients. Diversions can occur in many departments. When a hospital is under diversion, patients are sent to other available sites within the region. Every effort is made to divert a patient to the closest hospital.
- Health care worker shortages, intensified by the ongoing pandemic, have contributed to staffing shortages throughout BC and nationally. Staffing shortages and coverage challenges can be a result of:
    - Higher than normal sick call rates among existing staff
    - Challenges with recruitment of full-time positions
    - Challenges with retaining staff
    - National nursing and physician shortages
- At times, adverse weather events have impacted EDs (forest fires, flooding, freezing weather) which have resulted in diversions.

- Health authorities look at all options prior to implementing diversions. This includes looking to move staff between sites as able/needed; however, with staffing pressures across the health system, this is not always possible.
- Health authorities take steps to prepare for diversions, including advising BC Emergency Health Services as diversions may impact demand for ambulances in the area experiencing a diversion. Additionally, communities are advised via public service announcements which include information on how to safely access care.

Recruitment Efforts

- The Ministry of Health has recently developed a Health Human Resources Strategy, which has 70 concrete actions that will begin being implemented in 2022/23. These actions address staffing capacity issues throughout the health-care system and will help alleviate the burden on our health-care workers.
- Health authorities continuously work to recruit across all their vacancies, particularly in rural and remote communities, where a very small number of vacancies, annual leave or sick time can significantly disrupt the delivery of services. Recruitment efforts include incentives such as relocation assistance, rural retention grant and BC loan forgiveness.
- Interior Health Authority has worked to create new rotations where feasible, to support weekend coverage and stronger recruitment (such as in Ashcroft and Clearwater). Local tables have also been set up in some communities, made up of a variety of key stakeholders, to look at ways to support the delivery of health services in these rural communities.
- To stabilize and support staffing on northern Vancouver Island, Island Health Authority has enhanced staff recruitment and retention incentives for eligible staff with travel-wage increases, upgraded accommodations for travelling staff and increased protection-service officers to improve safety and site support.

LAST UPDATED

The content of this fact sheet is current as of February 7, 2023, as confirmed by Manpreet Khaira.

APPROVALS

2023 02 13 – Kristy Anderson, Hospital & Provincial Health Services Division
2023 03 24 – Maire McAdams obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

First Responder and Paramedic Scope Expansion

Topic: The Province has expanded the care Emergency Medical Assistants (EMAs) including First Responders (primarily firefighters) can provide to British Columbians in emergency situations.

Key Messaging and Recommended Response:

- **To improve patient care and overall safety, and in response to recommendations made by the Emergency Medical Assistants Licensing Board (EMALB), the Province expanded the care and treatment paramedics and first responders can provide in BC in 2021.**
- **BC Emergency Health Services (BCEHS) has made progress that will enable operational readiness for the scope of practice expansion, including:**
  - **Developing clinical practice guidelines;**
  - **Purchasing safes for controlled and targeted substances; and**
  - **Investing in new pieces of equipment and devices that are required to expand the scope of practice.**
- **Implementation is underway, with Driver to Emergency Medical Responders (EMR) training in progress.**
- **As of April 10, 2023, 19 drivers having successfully upgraded to EMR.**
- **Over 50% of drivers are enrolled in or have completed their EMR course, and over 40% are in the process of enrolling in an EMR course.**
- **Work is currently underway with the Justice Institute of BC (JIBC) to begin the development of the training modules with timelines for delivering the upskilling to be determined.**
- **A steering committee of involved parties has been established, meeting consistently to support collaborative practice.**
- **We are currently awaiting from JIBC the cost and implementation plan for delivering the training which is anticipated in late April 2023.**

CURRENT SITUATION

- The Emergency Medical Assistants Licensing Board (EMALB) is responsible for examining, registering, and licensing all EMAs in BC, including First Responders.

- At the direction of the Minister of Health (Minister), the EMALB developed a series of recommendations to improve patient care and overall patient safety by increasing the scope of all license levels to include new or expanded services.
- The legal scope of practice for EMAs at all license levels is determined by the Emergency Medical Assistants Regulation. Amendments were approved by the Minister and came into effect September 23, 2022 by way of Ministerial Order No. M292.
- The Ministerial Order has a transition period of September 2024, and while project work is underway, bridging training may not be fully completed by this date.
- These amendments align with the February 27, 2019, Office of the Auditor General report *Access to Emergency Health Services* that included a recommendation that BCEHS "determine an appropriate level of pre-hospital advanced care coverage that considers patient need, and implement strategies to achieve that level".
- BCEHS scope of practice expansion project operationalizes various sections of Schedules 1 and 2 of the updated EMA Regulations for the BC Ambulance Service.
- Funding commitments provide for BCEHS to educate employees to full Schedule 1, and some select Schedule 2 services such as IV analgesia for Primary Care Paramedics and above. Only EMRs will be trained to the complete Schedule 1 and Schedule 2 list of services.

Project Advancements

- Driver to EMR training for BCEHS employees is progressing. As of April 10, 2023, 19 drivers have successfully upgraded to EMR.
    - 57% (98 out of 171) of drivers are enrolled in or have completed an EMR course. BCEHS may request special exam sessions for the EMALB to expedite licensure.
    - 43% (73 out of 171) are in the process of enrolling in an EMR course.
- BCEHS has made progress that will enable operational readiness for the scope of practice expansion including developing clinical practice guidelines, and purchasing safes for controlled and targeted substances, and new pieces of equipment and devices that are required for elements of the scope expansion.
- While BCEHS is aiming to have bridging training of EMALB recognized programs underway for 2024/25, training programs remain undeveloped.
- Curriculum completion and rollout of bridging training will be determined by the pace of JIBC completion of training programs, with work underway.
- The Ministries of Health and PSFS, in partnership with BCEHS, are working with the JIBC to address the gap in upskilling/training programs. A steering committee of involved parties has been established, meeting consistently to support collaborative practice.
- In the latter part of March 2023, PSFS provided funding to JIBC, a publicly funded training institution, to lead the development of the upskilling modules in a way that supports Columbia Paramedic Academy and AET Paramedic Company – 2 private training institutions with open-source training modules for their use.
    - The upskilling modules are expected to be completed by JIBC in September 2023. Recognition by the Board will occur as expediently as possible but is dependant on the following: completeness of application packages, volume of submissions and capacity within the Branch.
- JIBC is currently working to develop a costing and implementation plan to deliver the scope expansion training. That proposal in expected in late April 2023.

FINANCIAL IMPLICATIONS

- In 2022/23 the Ministry of Health provided $750,000 through the Public Health Services Agency to BCEHS to support the scope of practice expansion.
- JIBC received $1,233,823 for curriculum and open-source module development supporting the implementation of paramedic scope of practice changes. Funding letter attached (ref. 128585).
- In addition, JIBC received $144,223 for minor capital purchases to support the implementation of the upskilling modules. (ref. 128615)

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- The changes to the regulations stem from recommendations made by the EMALB to provide better outcomes for patients needing emergency health services.
- The recommendations were made following the Board's consultation with stakeholders, including BCEHS, Ambulance Paramedics of BC (CUPE 873), BC Professional Fire Fighters Association, Fire Chiefs Association of BC, EMA recognized training program representatives, and paramedics in industry.
- As the proposed changes are implemented, EMAs will increasingly be able to provide improved care for patients on scene. For EMAs, this means the ability to provide a higher standard of care for patients, which at specific licensing levels can include:
    - Improved access to a range of analgesic (pain medications) options, including opiates.
    - enhanced airway management approaches
    - providing life supporting or sustaining medications during transport
    - needle decompression for major chest traumas to support breathing. Note: this applies to a small patient population and Primary Care Paramedics would only use in the case of traumatic cardiac arrest
- These changes are further supported by increases to the care that first responders can provide including:
    - additional diagnostic testing including blood pressure and blood glucose that can better inform paramedics about the next steps in patient care
    - administering epinephrine for a life-threatening allergic reaction
    - supporting the preparation or packaging of patients for transport
- The EMA Regulation defines six categories of licenses of EMAs in BC. As of April 1, 2023, there are 15,619 people holding valid EMA licences in BC.

License Level	# of EMAs
First Responder (EMA FR)	7,212
Emergency Medical Responder (EMR)	2,951
Primary Care Paramedic (PCP)	4,598
Advanced Care Paramedic (ACP)	735
Infant Transport Team (ITT)	21
Critical Care Paramedic (CCP)	132
Total EMAs in BC	**15,619**

LAST UPDATED

The content of this fact sheet is current as of April 13, 2023, as confirmed by Wendy Vowles, Director, Emergency Medical Assistants Licensing, and April 17, 2023, as confirmed by Eugene Johnson, ED, Provincial Services Branch.

APPROVALS

2023 02 25 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
2023 04 16 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 18 – Kristy Anderson, Hospital and Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Hospital at Home

Topic: Progress on implementing Government's commitment to provide a new Hospital at Home (HaH) program so patients can get safe care while in the comfort of their homes. HaH programs aim to increase hospital capacity by providing acute care to patients in their homes.

Key Messaging and Recommended Response:

- **The Hospital at Home (HaH) program provides patients with the choice to receive acute care in their own home.**
- **It allows eligible patients requiring acute care to be admitted to hospital but receive care at home from a multidisciplinary team led by a most responsible practitioner with hospital admitting privileges.**
    - **Currently physicians, but in the future this could also be nurse practitioners.**
- **HaH allows a subset of acutely ill patients to choose a safe, respectful and effective alternative to traditional in-patient treatment.**
- **By providing certain short-term acute care in the patient's home, HaH improves access and increases efficiency by reducing pressure on inpatient hospital beds, decreasing hospital congestion by optimizing patient flow, and improving overall system capacity.**
- **Current HaH prototype programs in Island Health and Northern Health are bringing significant benefits to patients and the health system, offering patient-centred care while increasing hospital capacity. Over 1,850 patients have received care at home via HaH instead of in hospital since program launch.**
- **The Ministry of Health is currently exploring options for potential expansion of HaH with heath authorities.**

CURRENT SITUATION

- Two prototype programs are in place, one in Vancouver Island Health Authority (VIHA) and the other in Northern Health Authority (NHA).
- Combined, the programs offer 24 HaH acute care beds to patients who meet eligibility criteria.
- Over 1,850 patients having been admitted into HaH prototype programs as of March 7, 2023.[1]
- Further program expansion will be considered following evaluation of the prototypes. Evaluation will provide an opportunity to refine the program and infrastructure supports (like technology, team composition). Any program expansion must consider the availability of health human resources.

1 Island Health HaH Update March 6, 2023, and Northern Health HaH Update March 1, 2023.

VIHA - 1,408 patients admitted into HaH as of March 6, 2023.[2]

- 18 HaH acute care beds.
- Victoria General Hospital - launched in November 2020 with 9 beds.
- Royal Jubilee Hospital - launched in March 2021 with 9 beds.
- Most responsible provider (MRP) services are provided by hospital-based physicians working exclusively on HaH for the duration of their shift.
- In April 2022, VIHA's HaH program won a national award for *Excellence in Patient Experience* from the Canadian College of Health Leaders. The award honours organizations and individuals who have set in place innovations that improve the human experience in healthcare.

NHA - 459 patients admitted into HaH as of March 1, 2023.[3]

- 6 HaH acute care beds at the University Hospital of Northern BC.
- Phase 1 (March 2021 to mid-May 2021) relied on community-based family physicians with hospital-admitting privileges who provided HaH as part of their family practice; however, there were challenges with the physician compensation model for Prince George community-based family practitioners.
- Phase 2 (current) prototypes an approach focused on caring for patients after surgery, using surgeons as MRP.

FINANCIAL IMPLICATIONS

On September 9, 2020, Government announced notional funding of up to $42.3 million to support the HaH initiative.Government Financial Information

Government Financial Information

KEY BACKGROUND

- In May 2020, Government committed to rolling out HaH provincially by winter 2020/21 in the BC COVID-19 Go-Forward Management Strategy.[4]
- The Health Sector Plan for Fall/Winter 2020/21 Management of COVID-19[5] and the December 2020 Speech from the Throne[6] also included commitments to HaH.
- Budget 2022 referred to the need for HaH to become a permanent program.[7]

Program Description

- HaH allows a subset of acutely ill, clinically stable patients who require hospital care to choose an alternative to traditional in-patient treatment that is still safe, respectful and effective.
- Patients receive daily in-person care supplemented by virtual care and monitoring, with 24/7 access to care.
- Patients are admitted to hospital but receive care at home from an interdisciplinary team led by a MRP (currently physicians but could also be Nurse Practitioners in future) with hospital admitting privileges.
- HaH patients are considered hospital inpatients, they can be transferred directly back to hospital, if needed, without going through the emergency department. Access to medically necessary general hospital services/resources (diagnostics, medications) is available in the same timely way as in a traditional hospital at no cost to the patient.
- Participation is entirely voluntary, and patients/caregivers can decline to participate or choose to return to hospital at any time.

2 Island Health HaH Update March 6, 2023.
3 Northern Health HaH Update March 1, 2023.
4 "*BC COVID-19 Go-Forward Management Strategy*." May 2022. p. 19.
5 *"Management of COVID-19: Health Sector Plan for Fall/Winter 2020/21."* https://news.gov.bc.ca/files/COVID-19_fall-winter_preparation.pdf
6 *"Speech from the Throne."* https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/42nd-parliament/1st-session/throne-speech. December 7, 2020.
7 "Stronger Together: Budget and Fiscal Plan 2022/23 – 2024/25." p. 44 and p. 130. https://www.bcbudget.gov.bc.ca/2022/pdf/2022_Budget_and_Fiscal_Plan.pdf.

BC HaH Patient Experience and Profile

- Patients and family caregivers report their experience of BC HaH care has been highly positive.[8]
- Common patient diagnoses have included: heart failure without coronary angiogram, lower urinary tract infection, cellulitis, viral/unspecified pneumonia, and chronic obstructive pulmonary disease.[9]
- While the BC HaH patient population is primarily older, patients have ranged from age 17 to 107.[10]

Benefits of HaH for Patients

Several Cochrane reviews, which represent the highest standard in meta-analysis, report the HaH model has fewer complications compared to traditional hospitalization such as fewer instances of delirium, blood clots, infection and functional decline.[11,12] Other benefits may include lower readmission rates, high satisfaction among patients/caregivers, and potentially fewer admissions to long-term care. This also allows for local hospitals to build capacity for patients that require acute inpatient care within hospital building.

LAST UPDATED

The content of this fact sheet is current as of February 3, 2023, as confirmed by Manpreet Khaira.

APPROVALS

2023 02 14 – Kristy Anderson, Hospital and Provincial Health Services Division
2023 02 15 – Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 21 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

8 Island Health HaH patient experience data November 2020 to November 2021.
9 Island Health HaH Patient Profile, October 2021.
10 Island Health HaH Update January 3, 2023.
11 Gonçalves-Bradley DC, Iliffe S, Doll HA, Broad J, Gladman J, Langhorne P, Richards SH, Shepperd S. Early discharge hospital at home. Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD000356. DOI: 10.1002/14651858.CD000356.pub4.
12 Shepperd S, Iliffe S, Doll HA, Clarke MJ, Kalra L, Wilson AD, Gonçalves-Bradley D. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews 2016, Issue 9. Art. No.: CD007491. DOI: 10.1002/14651858.CD007491.pub2

LEGISLATIVE SESSION – ESTIMATES NOTE

Hospital Capacity

Topic: Maintaining hospital capacity to ensure patients have timely access to emergency and acute care services is pivotal and a key priority especially during periods of increased demand due to respiratory illness season and COVID-19.

Key Messaging and Recommended Response:

- **The Ministry of Health reactivated Emergency Operation Centres (EOCs) in health authorities on January 6, 2023, as a proactive measure to ensure patients have continued access to quality hospital care during a period of high demand on the healthcare system.**
- **The Province and health authorities used the EOCs to ensure a coordinated and timely response to address the pressure from increased demand for hospital capacity during the respiratory illness season.**
- **Through the EOCs, the Ministry closely monitored hospital capacity and performance, and worked with the health authorities to address risk, barriers, and supports required to manage hospital surges.**
- **The province will continue to work in partnership with the health authorities to advance initiatives to manage hospital capacity and will launch provincial task groups to continue our work collectively to standardize best practices across the healthcare system.**

CURRENT SITUATION

- On January 6, 2023 the hospital census was 10,226, which was the second highest hospital census since May 2020 (January 5 was the highest at 10,280)[1].
- The average hospital census increased in January due to the restart of surgery, hospital staff returning from vacation, weather impacts and hospital staff illness during the holidays.
- Beginning on January 9, 2023, health authorities (HA) were directed to reactivate Emergency Operations Centres (EOCs) at 20 BC hospitals[2] that care for the most patients and prepare to sustain EOC operations for a period of at least 6 weeks.

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[1] Ministry of Health.[3765]. Daily Monitoring Dashboard for Covid-19 Sites. Retrieved from: https://hspp.healthideas.gov.bc.ca/framework/service-delivery/hospital-services/daily-monitoring-dashboard-covid-19-sites-100-pm-daily Last accessed on 2/24/2023 2:21:27 PM

[2]

IHA
East Kootenay Regional Hospital
Kelowna General Hospital
Kootenay Boundary Regional Hospital
Penticton Regional Hospital
Royal Inland Hospital
Vernon Jubilee Hospital

PHSA
BC Children's Hospital

NHA
Fort St John Hospital & Peace Villa
Mills Memorial Hospital
University Hospital of Northern BC

VCHA
Lions Gate Hospital
Richmond Hospital
St. Paul's Hospital
Vancouver General Hospital

VIHA
Nanaimo Regional General Hospital
Royal Jubilee Hospital
Victoria General Hospital

FHA
Abbotsford Regional Hospital and Cancer Centre
Royal Columbian Hospital
Surrey Memorial Hospital

- EOCs are a proactive step in the Province's plan to provide enhanced supports and a coordinated response to address expected additional pressures on hospitals due to increased surgeries and respiratory illness season.
- A provincial EOC was also established to monitor progress, continue to work with HAs to address and risks or barriers, and support plans and efforts as required to ensure patients receive timely access to care and with the right providers.
- As of 2019 data, BC had 1.8 acute care beds per 1,000 – compared to Canada which had 2.0 and to an Organisation for Economic Co-operations and Development peer country average of 2.9. [3]

Table 1: Hospital Occupancy Rates Pre and During COVID-19 Pandemic

Health Authority	Pre-COVID-19 Year Hospital Occupancy Rate 2019/20	COVID-19 Year 1 Hospital Occupancy Rate 2020/21	COVID-19 Year 2 Hospital Occupancy Rate 2021/22 (Apr 1, 2021 –Mar 31, 2022)	Percentage Point Change 2021/22 (from pre-Covid 2019/20
Interior Health Authority	99.8%	88.3%	101.2%	1.4
Fraser Health Authority	105.2%	95.3%	107.4%	2.2
Vancouver Coastal Health Authority	98.4%	89.6%	99.3%	0.9
Island Health Authority	101.8%	90.0%	100.5%	-1.3
Northern Health Authority	103.2%	87.8%	99.8%	-3.4
Provincial Health Services Authority	80.1%	73.7%	74.2%	-5.9
BC Average	100.7%	90.2%	101.0%	0.3

Hospital Occupancy Rate Report – 22-23 Q3, updated February 1, 2023, RMS 1407 Analytics Product Library - Alphabetical (gov.bc.ca)

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

EOC Operations

- EOCs were to stay in place until at least February 17, and were still in operation as of March 1. They will ensure dedicated leadership teams are reviewing hospital bed availability and identifying solutions to ease emergency department (ED) congestion.
- These actions increase patient flow so that the most vulnerable patients, including those who need critical care, get the care they need. Actions include:
    - Leadership teams helping safely transition patients who are ready to be discharged from hospital.
    - Resources available seven days a week to support hospital units at the 20 BC hospitals that care for the most patients.
- The EOCs build on actions underway since fall 2022. As part of the Emergency Department and Hospital Capacity Task Group work (the Task Group), in late September 2022, HAs and the Task Group came together to share initiatives already in place to support ED and hospital capacity, as well as identify new initiatives or strategies for further exploration.
- Integrated into HA surge response plans, these initiatives support capacity management across the continuum of care which:
    - Strengthen community support to avoid ED visits and/or admissions
    - Reduce length of hospital stays for acute and Alternate Level of Care patients

[3] CIHI OECD Interactive Tool: International Comparisons – Peer countries, British Columbia, 2019 Accessed February 13 2023 https://www.cihi.ca/en/oecd-interactive-tool-international-comparisons-peer-countries-british-columbia

  - Ensure there are appropriate assisted living, long term care, mental health and substance use, at home, and housing supports to support discharge of transitional and complex care patients
  - Support patients, hospital leaders, health care practitioners and staff
- Work is underway to identify which of the other new Task Group initiatives could be explored in partnership by the Ministry of Health, HAs, Emergency Care and Critical Care Health Improvement Networks for implementation and standardized across the system.
- Daily EOC hospital reporting monitors rates and trends for HA-specific admission avoidance activities and accomplishments, discharge enhancements and Alternate Level of Care patient conversion and reduction (See Alternate Level of Care Fact Sheet).
- Barriers to capacity improvements are identified quickly and the Ministry of Health provides a coordinated response to provide necessary resources and collaboration with other ministries.

LAST UPDATED

The content of this fact sheet is current as of February 8, 2023, as confirmed by Manpreet Khaira.

APPROVALS

2023 02 14 – Kristy Anderson, Hospital & Provincial Health Services Division
2023 03 01 – Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

MAiD – General Overview

Topic: An overview of the provision of Medical Assistance in Dying (MAiD) in BC and its associated monitoring, reporting, and oversight structures.

Key Messaging and Recommended Response:

- **Federal legislation sets out the eligibility criteria for Medical Assistance in Dying (MAiD) and the safeguards that must be followed.**
- **To be eligible, an individual must be eligible for health services funded by a government in Canada, must be at least 18 years of age and capable of making decisions about their health care, must have a grievous and irremediable condition, must be making a voluntary request for MAiD, and must give informed consent for MAiD after having been informed of other means of alleviating their suffering.**
- **Safeguards for MAiD include: the request must be made in writing and signed before an independent witness, at least two doctors or nurse practitioners must find the individual eligible, the individual must be informed that they can withdraw their request at any time, and they must give express consent immediately prior to receiving MAiD (unless a waiver of final consent is used).**
- **In BC, we provide medical assistance in dying as an end-of-life option in a manner that is safe, respectful and supportive of patients, families and providers.**
- **Our provincial system of oversight and reporting ensures public safety and confidence in this service.**
- **The Ministry of Health's MAiD Oversight Unit reviews every single case of MAiD for compliance with the eligibility criteria, safeguards, and practice standards, regardless of whether a complaint is received.**
- **If concerns are identified, the oversight unit may provide education, make a referral to the applicable professional college, or make a referral to law enforcement, as required.**
- **Since the unit took over responsibility for oversight of MAiD from the BC Coroner's Office in November 2018, the unit has made 18 referrals to regulatory colleges and two to law enforcement. The number of referrals to regulatory**

colleges and law enforcement represent less than 0.3% of the total number of cases reviewed by the MAiD Oversight Unit.

CURRENT SITUATION

- Patients have the right to make decisions about their own health care and their wishes are paramount. BC is committed to ensuring access for all eligible patients who choose to exercise their right to MAiD.
- In 2022, there were 2,515 medically assisted deaths, a 23.9% increase over 2021. Of these, 97.5% (2,453) were individuals who were facing a reasonably foreseeable natural death (i.e., who had a terminal condition), whereas 2.5% (62) were not.
- There were 51 transfers due to a facility's policy on MAiD, representing 2% of MAiD provisions that year. Of these transfers, Personal Information Personal Information
- Providence Health Care (PHC), which does not allow MAiD provision at its sites, operates several facilities, including St. Paul's Hospital and St. John's Hospice, within VCHA. In 2023, PHC will acquire May's Place hospice facility, Central City Lodge long-term care facility, and Cooper Place assisted-living facility. Personal Information Personal Information
- All MAiD provisions in BC are required to be reported to the MAiD Oversight Unit, within the Ministry of Health, for the purposes of monitoring, reporting, and oversight.
- Federal reporting and monitoring regulations set out the information that must be collected as part of the MAiD process, including information about the individual requesting MAiD and their eligibility as well as information from the doctors or nurse practitioners involved, including that the safeguards were followed. In BC, this information is collected by the MAiD Oversight Unit and reported to the federal government quarterly.
- The federal regulations were updated on January 1, 2023, expanding mandatory data collection to include additional demographic information such as gender identity, race, indigenous identity, and disability information about individuals seeking MAiD (with their consent) to create a broader picture of MAiD recipients in Canada. These changes have been fully implemented in BC.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- The *Criminal Code of Canada* sets out the eligibility criteria and safeguards for MAiD.
- To be eligible, the individual (1) must be eligible for health services funded by a government in Canada, (2) must be at least 18 years of age and capable of making decisions about their health care, (3) must have a grievous and irremediable condition, (4) must be making a voluntary request for MAiD, and (5) must give informed consent for MAiD after having been informed of other means of alleviating their suffering.
- Safeguards for MAiD include that (1) the request must be made in writing and signed before an independent witness, (2) at least 2 doctors or nurse practitioners must find the individual eligible, (3) the individual must be informed that they can withdraw their request at any time, and (4) they must give express consent immediately prior to receiving MAiD (unless a waiver of final consent is used).
- On March 17, 2021, the *Criminal Code of Canada* was amended to expand eligibility for MAiD to patients whose natural death is not reasonably foreseeable. These cases are subject to additional safeguards, which include (1) 1 of the 2 doctors or nurse practitioners (NP) assessing the individual must have expertise in the condition causing the individual's suffering (or a third doctor or NP with such expertise must be consulted), (2) at least 90 days must elapse between the start of the first assessment and when MAiD is provided, and that (3) the individual must give serious consideration to other means of alleviating their suffering before MAiD is provided.

- Patients whose sole underlying medical condition is mental disorder are currently not eligible for MAiD services. The *Criminal Code of Canada* includes a sunset clause that removes this exclusion on March 17, 2023. However, on December 15, 2022, the federal Justice and Health Ministers announced their intentions to further extend the removal of the sunset clause through a legislative amendment (see "MAiD – Mental Disorder as the Sole Underlying Medical Condition" fact sheet).
- Oversight of MAiD in BC is provided by the Ministry of Health's MAiD Oversight Unit:
    - Doctors and NPs who provide MAiD in BC must submit all required documentation to the MAiD Oversight Unit within 72 hours of a MAiD provision.
    - This includes documentation of the patient's request for MAiD, the doctor or NP's own assessment of the patient's eligibility, the assessment of a second doctor or nurse practitioner, and a medication administration record.
    - All documentation is reviewed by the MAiD Oversight Unit for compliance with the eligibility criteria, federal safeguards, federal regulations, provincial safeguards and professional regulatory college practice standards for MAiD.
    - If concerns are identified, the MAiD Oversight Unit may provide education, make a referral to the applicable professional college, or make a referral to law enforcement, as required.
- The Medical Assistance in Dying: Access and Care Coordination policy (the MAiD policy) outlines the Ministry of Health's expectations of HAs regarding the delivery of MAiD services. HAs are responsible for ensuring that MAiD is reasonably available in a manner like other end-of-life health care services. Each HA has a MAiD care coordination service which helps patients and health care providers access services.
- In addition to HA owned/operated facilities, the MAiD policy delivery expectations extend to contracted organizations (e.g., long-term care facilities, hospices, assisted living residences and other settings) that receive more than 50% of their bed funding from HAs.
- Contracted organizations that have 50% or less of their beds funded by HAs may decline to allow the provision of MAiD; in this case, those contracted organizations must:
    - Provide a notification of their refusal to allow the provision of MAiD, including all Board of Directors signatures, to the HA;
    - Provide a copy of the contracted organization's most recent fiscal year financial statement, and any other additional required financial information requested, to the HA;
    - Inform individuals of their policy prior to consent to admission; and
    - Clearly post their policy related to MAiD on their website.
- A faith-based organization, defined as an organization that is a party to the Master Agreement with the Denominational Health Care Facilities Association or otherwise in its constitution declares itself as being an organization based on religion or spirituality, is exempt from the requirement to allow access to MAiD regardless of the level of funding it receives.
- Federal legislation states that no person will be forced to provide or help to provide MAiD. This exemption applies to individuals but does not cover organizations. If a doctor or NP chooses not to provide MAiD, patients can expect to be treated with respect and be provided with an effective transfer of care.

LAST UPDATED

The content of this fact sheet is current as of February 8, 2023, as confirmed by Manpreet Khaira.

APPROVALS

2023 02 11 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

MAiD – Mental Disorder as the Sole Underlying Medical Condition

Topic: Individuals with a mental disorder as their sole underlying medical condition (MD-SUMC) are currently excluded from eligibility for medical assistance in dying (MAiD); however, this is expected to change in the near future.

Key Messaging and Recommended Response:

- **We have a provincial system of oversight and reporting to ensure public safety and confidence in Medical Assistance in Dying (MAiD).**
- **MAiD for individuals with a mental illness as their sole underlying condition is a sensitive issue that requires a careful and well-considered approach.**
- **The federal government's decision to seek an extension to the exclusion period for mental disorder will allow provinces and territories more time to prepare for the implementation of this change.**
- **Work is underway to prepare for this change in BC, including the development of additional safeguards to protect patients and ensure safe and appropriate access to MAiD, as well as practice standards and resources to ensure that practitioners are well positioned to assess requests in a safe and compassionate manner.**
- **Additional safeguards for individuals who do not have a reasonably foreseeable natural death (i.e. who do not have a terminal condition) include that one of the two doctors or nurse practitioners assessing the individual must have expertise in the condition causing the individual's suffering (or a third doctor or nurse practitioner with such expertise must be consulted), at least 90 days must elapse between the start of the first assessment and when MAiD is provided, and that the individual must give serious consideration to other means of alleviating their suffering before MAiD is provided.**

CURRENT SITUATION

- The federal *Criminal Code of Canada*, which governs MAiD, currently excludes mental illness from eligibility for MAiD.
- While this exclusion would be repealed on March 17, 2023, when a sunset clause comes into force, the federal Ministers of Justice, Health, and Mental Health and Addictions announced in December 2022 that the federal government would work with Parliament to amend the legislation and extend the exclusion period for mental illness.
- The length of this extension is currently unknown.

- Work is underway to prepare for the expansion of eligibility in BC, including the development of new safeguards to protect patients and ensure safe and appropriate access to MAiD, as well as practice standards and resources to ensure that practitioners are well positioned to assess requests in a safe and compassionate way.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- In preparation for the legislative change which will allow individuals with MD-SUMC to become eligible for MAiD, a provincial Subcommittee on MAiD and mental health has been formed to advise on any new provincial safeguards required for this population, as well as resources and guidance required by MAiD assessors and providers in BC.
- The Subcommittee includes members with both clinical and operational expertise in MAiD and mental health, as well as representation from the Ministry of Health, Ministry of Mental Health and Addictions, and Ministry of Social Development and Poverty Reduction.
- The Subcommittee is in the process of developing recommendations for new provincial safeguards.
- Provincial safeguards for MAiD in BC are embedded within the practice standards of BC's regulatory colleges. Once the new provincial safeguards for MD-SUMC are finalized, the Ministry of Health will work with the College of Physicians and Surgeons of BC (CPSBC), the BC College of Nurses and Midwives (BCCNM), and health authorities to implement them.
- While the federal government has not yet indicated the length of the extension, they are seeking to the exclusion period for mental disorder, an extension to the exclusion period will help ensure BC is better prepared to handle these types of MAiD requests.
- A federal Parliamentary committee, the Special Joint Committee on MAiD, is also conducting a comprehensive review of the *Criminal Code of Canada* provisions for MAiD and their application, as well as "issues relating to mature minors, advance requests, mental illness, the state of palliative care in Canada and the protection of Canadians with disabilities." The committee could potentially recommend new federal legislative safeguards for MAiD MD-SUMC; its final report is expected to be tabled in Parliament in February.

LAST UPDATED

The content of this fact sheet is current as of February 3, 2023, as confirmed by Manpreet Khaira.

APPROVALS

2023 02 08 – Kristy Anderson, Hospital & Provincial Health Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Nursing Support Services

Topic: Nursing Support Services (NSS) is a provincial program operated by the Provincial Health Services Authority (PHSA) through the BC Children's Hospital (BCCH). NSS provides support to families/guardians of children with chronic, complex health conditions (birth to 19 years) for whom aspects of their community care needs require the knowledge, judgement/skill of a licenced nurse.

Key Messaging and Recommended Response:

- **Nursing Support Services (NSS) provides care for children and youth whose medical and care needs require the scope of practice of a licensed nurse. There are two streams of care: Delegated Nursing Care and In-Home Nursing Respite Care.**
- **Delegated nursing care, as defined by the BC College of Nurses and Midwives, is intended for rare and exceptional circumstances. Delegations are enacted on a case-by-case basis and several factors; including the complexity of care, skill required, and environment, must be considered for a nurse to determine if they can safely delegate care.**
- **The decision to delegate is nurse specific as they ultimately hold the overall accountability and responsibility for each delegation they enact under their professional practicing license and are responsible for the ongoing monitoring and supervision of each delegation they enact.**
- **Delegation requires that the child has a stable condition with a predictable and expected response to the medical care tasks that are provided routinely by individuals tasked with this care on a consistent basis to maintain their knowledge and skills.**
- **Training provides general information and skills education to non-medical staff about aspects of care. Nurses do not hold the overall accountability and responsibility for ongoing monitoring or supervision.**
- **NSS does not currently provide services (training or delegated care) in the childcare setting.**
- **It's outside the scope of the NSS program to provide training in any context with exception to provide training support on seizure rescue interventions in the K-12 school setting.**

- **Parents and guardians are experts in their child's care and they are encouraged to work with their childcare provider to educate staff on how to best meet the needs of their child.**
- **The goal of NSS is to enable children living with complex health conditions, and their families, to lead active, healthy lives in their home communities.**
- **We know children with complex medical needs, and their families, face unique challenges, and the Ministry of Health is committed to ensuring they receive the support they need, when and where they need it.**

CURRENT SITUATION

The goal of NSS is to enable children living with health complexity and their families to lead active, healthy lives in their home communities. There are 2 streams of care: Delegated Nursing Care and In-Home Nursing Respite Care.

Delegated Nursing Care

- As of January 26, 2023, approximately 635 children are receiving Delegated Nursing Care.
- In late Spring 2022, it was determined that delegating the administration of seizure rescue medication to non-medical school staff falls outside the scope of care a registered nurse is allowed to delegate per BC College of Nurses and Midwives (BCCNM) scope of practice.
- A working group was established in late Spring 2022 to examine issues related to NSS delegated care and seizure rescue medication administration in the school setting with representation from NSS, the Ministry of Education and Child Care (ECC), the Ministry of Health (MoH), including the Nursing Policy Secretariat, Pharmacy, Professional Regulation, and BCCH Division of Neurology. The working group recommended the transition to a training model as implemented this year.
- School districts and families were directly notified of the change on September 9, 2022, by joint communication from NSS and MoH. Information and resources have also been shared publicly on the NSS and ECC websites.
- As an interim measure, and to ensure that children requiring the administration of seizure rescue medication can receive it, NSS is providing training to school staff for the administration of this medication for the 2022/23 school year. Since the inception of this change, NSS has received 214 requests provincially for seizure rescue intervention training in schools.
- With this change, the school employee performing the task is no longer providing care under the nurses' professional practicing license but instead is covered by Section 14 (b) of the *Health Professions Act* that allows for persons not designated as health professionals to give first aid or temporary assistance in an emergency.
- The working group continues to meet to develop a long-term solution beyond the 2022/23 school year.

In-Home Nursing Respite Care

- As of January 26, 2023, 207 children and youth are receiving In-Home Nursing Respite Care, with 65 of those children and youth eligible for In School Support (ISS) hours.
- In-Home Nursing Respite Care has been affected by COVID-19 due to staffing shortages and families suspending/reducing services. Most families have resumed services, although some continue to choose to have reduced services or have services on hold. Staffing remains a focus in all areas; rural and remote areas are the most impacted. Nursing agencies are continuing recruitment efforts.
- In response to the COVID-19 pandemic and family concerns about children attending school in-person, starting in the 2020/21 school year, NSS allowed an exemption for families to use ISS hours in the home as

additional respite during the time that children would have normally been attending school. This temporary exemption has continued into the 2022/23 school year in light of unprecedented respiratory illnesses that have significantly affected the pediatric population this year. NSS is aiming to ensure that these hours are in alignment with their intended purpose to support a child's attendance for in-person instruction at school for the 2023/24 school year.

- In early 2022, government approved the PHSA's business plan for a new children's complex care transition centre (Slocan Site Redevelopment Project) that will house a range of services for children and youth living with health complexity including the NSS program. Construction is planned to begin in 2025, with the centre opening to the public in 2028.

FINANCIAL IMPLICATIONS

The budget for NSS in 2022/23 is $30.64 million. This is an increase of $0.01 million from the budget for 2021/22 of $30.63 million. 2021/22 actual expenditures were $28.81 million.

KEY BACKGROUND

NSS provides care for children and youth whose care needs require the scope of practice of a licenced nurse for some aspects of their care due to the child/youth's medically complex and fragile health needs. NSS does not have a wait list and accepts children as they are eligible. There are 2 NSS programs:

1. **NSS Delegated Nursing Care**
    - Provides training/ongoing monitoring of unregulated caregivers (educational assistants) in school settings to provide specific aspects of a child's care, such as gastronomy tube meals, blood glucose monitoring and insulin administration, clean intermittent catheterization, and oral suctioning. Delegation of care is in accordance with BCCNM practice standard for delegation.
    - Nurses may only delegate tasks for which they are permitted by their regulatory college to perform autonomously and delegation to unregulated care providers requires a stable condition with a predictable response to care.
        - Seizure rescue medications (Ativan and Midazolam) are classified as Schedule 1 drugs under the *Pharmacy Operations and Drug Scheduling Act*, Drug Schedules Regulation. Nurses require an order from the prescribing physician to administer seizure rescue medications and are unable to delegate this task under the *Health Professions Act* and autonomously within their scope of practice.

2. **NSS In-Home Nursing Respite Care**
    - NSS In-Home Nursing Respite Care provides parents/guardians with scheduled, intermittent periods of respite up to a maximum of 56 hours per week. Families may be eligible for an additional 10 hours/week of home hours if the child/youth has extraordinary care needs and no secondary form of respite (e.g., school/preschool/other funding, extended family) is available. The current program average is 40 hours per week.
    - As a respite service, it is an expectation that families are prepared, capable and able to provide all aspects of their child's care in the absence of nursing. NSS is not an emergency response service nor does the program provide interventional care such as home IV or post-operative care (e.g., dressing changes).
    - All children eligible for In-Home Nursing Respite Care are required to have, at minimum, an annual comprehensive nursing assessment to determine their current medical/nursing care needs. Allocation of nursing respite hours reflect a child's care needs that require the scope of a licensed nurse.
    - Families eligible for In-Home Nursing Respite Care may also receive ISS hours to enable eligible children to attend in-person, classroom instruction at school. NSS determines eligibility for ISS hours based on required care that can only be provided by parent and/or specially trained adult during the time the child is at school. ISS hours are subject to change in response to a child's attendance at school—these hours may increase as a child's attendance increases (to a maximum of 30 hours/week, consistent with a typical school day) or they may decrease if families choose not to send their child to school.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of February 2, 2023, as confirmed by Eugene Johnson.

APPROVALS

2023 02 11 – Kristy Anderson, Hospital & Provincial Health Services Division
2023 02 25 – Rob Byers, Finance & Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Post COVID Clinics

Topic: The Post-COVID-19 Interdisciplinary Clinical Care Network (PC-ICCN) aims to support the best possible outcomes for people experiencing symptoms of long COVID that are impacting their day-to-day lives. The Network does this through research, education, and care.

Key Messaging and Recommended Response:

- **For those with lasting effects after their COVID-infection, which in some cases is long-COVID, it's important they have access to care they need when they need it.**
- **Long-COVID patients are able to access services through the Post-Covid Interdisciplinary Care Clinic Network (PC-ICCN), provincewide.**
- **Previously in BC, there were 4 Post-COVID Recovery Clinics that operate under a hub-and-spoke model as part of the PC-ICCN.**
- **The number of patients being referred to PC-ICCN has been decreasing. For example, there were 121 referrals from across the province in December 2022 compared to 394 in December 2021.**
- **As the number of new referrals has been consistently decreasing over time, PC-ICCN decided to evolve its model of care to better serve patients provincially.**
- **As a result, the Post-COVID Recovery Clinics have consolidated into a single virtual clinic and offer province-wide access to care, starting April 1, 2023.**
- **Currently, more than 1,500 patients across the province are accessing these services and they will continue to get the care they need.**
- **Since its inception, the Network has supported a total of 4,216 patients.**
- **Consistent with past practice, new patients will continue to be welcomed through referral.**

CURRENT SITUATION

- Due to emerging evidence about optimal care and a decrease in patients, the Network is evolving its model of care to better reflect current demands and patient needs.
- As a result, the Ministry of Health committed ongoing funding ($5 million annually) for the following:
- **For Clinical Care**: As of April 1, 2023 Post-COVID Recovery Clinics will consolidate into a province-wide virtual clinic at St. Paul's Hospital serving patients throughout BC. PC-ICCN staff and approximately 1,500 patients are currently being made aware of these changes. Patients are being transitioned to their family doctor, other primary care provider, or the centralized clinic for ongoing virtual care.

  - Maintaining continuity of care is a priority for the Network. Therefore, patients requiring care will stay with the Network and transition to the provincial virtual clinic. Patients will continue to access support from a multidisciplinary healthcare team, including physiotherapists, occupational therapists, social workers and physicians as required.
  - Consistent with past practice, new patients will continue to be welcomed through referral. A specialized post-COVID nurse will be assigned to each patient as a case manager. Based on their symptoms, patients will receive immediate access to the most appropriate self-management supports, including group learning opportunities based on individual needs and physician assessment as required.
  - The consolidated provincial clinic will continue to focus on supporting symptom management and functional improvement for patients. Similar to the regional clinics, visits will be almost exclusively virtual. Patients will have access to a variety of tools, including education sessions, to help with symptom management and recovery. Patients can also access group therapy and individual appointments depending on individual recovery needs.
- **For Network**: PC-ICCN will continue as a knowledge sharing and research network, serving patients and providers through online resources.
  - PC-ICCN will continue to support health-care providers by sharing resources, emerging evidence, best practices, and guidelines via www.phsa.ca/postCovid.
  - The Post-COVID Rapid Access to Consultative Expertise (RACE) line will continue to provide guidance for primary care to support long COVID patients.
  - Other activities include: (1) Re-evaluate the current education needs of community providers and create new offerings in keeping with identified needs and emerging research, (2) Support research coordination and integration through a multi-year $20 million CIHR research grant - the "Long COVID Web" project, which will be co-led by Dr. Adeera Levin, Scientific Co-Director, alongside national partners, and (3) Additional efforts to bring together health system teams supporting patients with complex chronic conditions (e.g. CDDP at BC Women's) to explore learnings from long COVID and make concrete recommendations regarding service delivery models.
- Consolidating the clinics is backed by evidence: current data gathered in BC and elsewhere has shown that many people living with long COVID benefit most from self-management tools and strategies. Hospital-based care is not the best way to help people with long COVID recovery.
  - The number of patients being referred to PC-ICCN has been decreasing. For example, there were 121 referrals from across the province in December 2022 compared to 394 in December 2021[1].
- Since its inception, the Network has supported a total of 4,216 patients. Of these, 3,805 patients were seen through 9,123 total clinic visits, both virtual and in-person. More than 1,200 patients showed improved symptoms and were discharged[2].
  - As of March 8, 2023, there have been 7,682 referrals to PC-ICCN.
    - 4,764 of these referrals were appropriate.
    - 2,918 referrals were inappropriate due to reasons such as timing/eligibility or staff being unable to contact the patient.
  - As of March 8, 2023, there were 9,123 clinic visits in total.
    - 3,850 patients have had at least one clinic visit (in-person or virtual).
  - As of March 8, 2023, 2,436 patients have successfully transitioned out of the Network. Of these:
    - 411 were provided with education and resources by Central Triage.
    - 1,324 showed improved symptoms after visiting the recovery clinics and were discharged.
    - 701 patients successfully completed an 18-month treatment pathway.
- There have been no new referrals to the regional recovery clinics since January 1, 2023[3]; those who are currently awaiting clinical will be seen by the allied clinical team before being transferred to their primary care provider or the centralized virtual clinic.

[1] Source: PROMIS database. March 8, 2023
[2] Source: PROMIS Database. March 8, 2023
[3] Source: PROMIS database. March 8, 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

- $5 million annually to support PC-ICCN central infrastructure and consolidated provincial clinic.
- $1.5 million was provided to the St Paul's Foundation from the REKMF in 2021/22.
- Funding for the regional clinics was managed centrally through PC-ICCN (June 2022 – March 2023). Moving forward, PC-ICCN will continue to provide permanent funding and support for the consolidated provincial clinic.

KEY BACKGROUND

- PC-ICCN was conceived in April 2020 and formalized in the Fall of 2020, as more and more people were living with symptoms of long COVID.
- PC-ICCN established standardized care pathways and tools for people living with post-COVID symptoms, including in-person clinics, online resources, provider education and clinic resources, and research. PC-ICCN coordinates access to resources and services through a central triage team.
- Four Post-COVID Recovery Clinics (PCRCs) were established in Vancouver Coastal/Providence Health Care (Vancouver General Hospital, St. Paul's Hospital) and Fraser Health (Jim Pattison Outpatient Care and Surgery Centre, Abbotsford Regional Hospital). In March 2022, a fifth clinic opened at Royal Jubilee Hospital in Victoria. Northern Health and Interior Health opted for a community navigation model.
- BC was the first jurisdiction in Canada to recognize a need to support people living with long COVID by standardizing care across health authorities and integrating real-time research into clinical care.
- There is still no single medical treatment (medications) for long-term symptoms of COVID-19.
- PC-ICCN has adapted its services in response to the rapidly evolving pandemic and learning health system cycles, using data to inform clinical and operational decisions.
- As the Network learned more about managing long COVID, it refocused on patient education and self-management.
- Referrals to PC-ICCN have been decreasing since May 2022. Patient volumes could not justify 2 interdisciplinary teams within the Vancouver Coastal Region, resulting in the merging of the VGH and SPH clinics in September 2022.
- BC continues to face a human health resources crisis. Nursing and allied health professionals are asked to return to their previous positions. Post-COVID Recovery Clinics struggle with high turnover due to the temporary nature of funding. However, ongoing $5 million funding has now been secured.
- In October 2022, PC-ICCN shifted to an education-first approach to care, only prioritizing patients for clinic visits if they did not see any improvement after completing the education program.
- Research is a key component of the clinics and the Network. PC-ICCN is actively coordinating patient-oriented research in BC and participating in national and international studies to better understand people's experience of "long COVID."
- All patients referred to PC-ICCN are recorded in a provincial registry.
- PC-ICCN's network structure continues to have several potential benefits for the health care system, including reducing hospital re-admissions for lingering COVID-19 symptoms, coordinating specialist referrals, and reducing redundant lab and diagnostic testing.

LAST UPDATED

The content of this fact sheet is current as of April 14, 2023, as confirmed by Eugene Johnson.

APPROVALS

2023 04 14 – Kristy Anderson, Hospital and Provincial Health Services Division
2023 04 14 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Surgical Renewal

Topic: Update on the May 7, 2020, Minister of Health announcement regarding the Commitment to Surgical Renewal; a $250 million plan to increase surgical capacity to address postponed non-urgent scheduled surgeries due to the COVID-19 pandemic and meet growing demand for surgery[1].

Key Messaging and Recommended Response:

- **BC was one of the first provinces in Canada to start the work to catch up on surgeries postponed by the pandemic, in May 2020.**
- **Despite additional waves of COVID-19, the toxic drug crisis and the global health workforce shortage, we continue to make excellent progress on surgical renewal.**
- **During Year 2 of Surgical Renewal (April 1, 2021 to March 31, 2022), we completed 337,560 surgeries. This is the highest number of surgeries ever performed in a year in BC.**
- **As noted in CIHI's latest report, BC ranks first nationally for the percent of patients meeting clinical benchmarks for cataract surgeries.**
- **We rank second nationally for the percent of patients meeting clinical benchmarks for both hip and knee replacements.**
- **We were one of two provinces that did not experience a significant decrease in surgeries after the first six months of the pandemic.**
- **This incredible progress would not be possible without investments into our public healthcare system and increasing operating room time and capacity in the health authorities. We have been working hard to have all the health authorities running above pre-COVID surgical capacity as part of our overall goal to ensure patients have access to surgeries.**
- **We are focused on building on existing achievements, continuing to overcome challenges and finding new ways to deliver the surgeries patients need.**
- **It's the ongoing hard work by all of us that will see Year 3 (2022/23) of our surgical renewal commitment deliver further achievement in what matters**

[1] BC Gov News. (May 7, 2020). Province Launches Renewal Plan for Surgeries. Retrieved from: https://news.gov.bc.ca/releases/2020HLTH0026-000830

most – focusing on patients, increasing surgeries and increasing essential personnel.

CURRENT SITUATION

- Surges of COVID-19 variants and severe weather events have impacted ongoing surgical renewal efforts across the province due to required postponements of surgeries to protect hospital capacity and redeploy surgical staff to support other areas of the acute care system.
- All surgeries postponed due to COVID-19 are tracked and monitored for completion[2]. The following results are for patients that had their surgery postponed and still wanted to pursue a surgical treatment:
  - **Patient Cohort 1** (March 16 – May 18, 2020): As of January 5, 2023, 99.9% of the 14,783 patients have had their surgery completed (4 cases remaining).
  - **Patient Cohort 2** (November 20, 2020 – June 11, 2021): As of January 5, 2023, 99.5% of the 3,161 patients have had their surgery completed (16 cases remaining).
  - **Patient Cohort 3** (June 12, 2021 – February 4, 2022): As of January 5, 2023, 98.7% of the 6,606 patients have had their surgery completed (89 cases remaining).
- As a result of the extreme heat, wildfires, floods, the shortage of health human resources and multiple and sustained COVID-19 impacts, Advice/Recommentations
  Advice/Recommentations
- Advice/Recommentations ; other gains have been made. These include:
  - On July 13, 2021, the Ministry of Health issued a refreshed Waitlist Management Policy that all six HAs have implemented as of Q3/P09. Policy implementation will support improved accuracy of reported wait times through enhanced sharing of patient unavailable time, improved BC Diagnosis Code selection by surgeons, and routine waitlist audits by HAs and surgeons. In addition, improved patient communication has resulted through Patient Notification letters and phone calls.
  - Fiscal 2022-23 mid-year surgical renewal achievements include the following[4]:
    Between April 1, 2022 to November 10, 2022:
    - Delivery of 215,188 scheduled and unscheduled surgeries – 7,663 surgeries or 4% more compared to the same timeframe as 2019
    - Delivery of 20,425 urgent scheduled surgeries completed within four weeks – 6% more compared to the same timeframe as 2019
    - Delivery of 18,733 non-urgent surgeries for patients waiting longer than two times their target wait – 13% more compared to the same timeframe in 2019
    - Expansion of operating room hours by 17,796 to 376,399 hours – 5% more compared to the same timeframe as 2019
    - Addition of 19 new initiatives in health authorities to increase operating room time and capacity

    As of November 10, 2022:
    - Reduction by 6% of the total waiting-list size compared to the same time in 2019

    Since April 2020:
    - Completion of training by health authorities of an additional 180 surgical specialty nurses, bringing the total trained to 798 throughout BC since April 2020
    - Addition of net new health-care staff to surgical services throughout BC, including 125 surgeons, 106 anesthesiologists, 181 perioperative nurses, 80 general practitioner anesthetists and 76 medical device reprocessing technicians since April 2020

[2] Health Sector Information, Analysis & Reporting, Health System Analytics RMS 2469 SWT COVID-19 Postponement Cancel Codes, 2022/23 Period 10 Results, Site 342.
Advice/Recommentations
[4] BC Gov News. (December 19, 2022). BC delivers on Surgical Renewal Commitment: Patients get their surgeries. Retrieved from: https://news.gov.bc.ca/releases/2022HLTH0236-001917

- The Ministry continues to work with HAs to find ways to increase health human resources for surgery while balancing other strategic priorities that draw nursing staff including primary and acute care.

FINANCIAL IMPLICATIONS

- In addition to the initial $250 million investment, on September 9, 2020, the Government announced the Ministry of Health received approval to access operating funding of up to $1.6 billion and capital funding of $150 million in 2020/21 to respond to the health-care requirements related to the COVID-19 pandemic response[5]. Of this amount, approximately $187.5 million was allocated to support enhanced surgical capacity, including additional nursing staff and operating room costs.
- Budget 2021 provided an additional $495 million over 3 years to continue to support the surgical and diagnostic imaging strategy activities.

KEY BACKGROUND

- On March 16, 2020, non-urgent scheduled surgeries were postponed because of COVID-19, and on May 18, 2020, non-urgent scheduled surgeries resumed.
- The Commitment to Surgical Renewal launched May 7, 2020 and outlines 5 steps: 1) increasing surgeries; 2) increasing essential personnel; 3) focusing on patients; 4) adding more resources; and 5) reporting on progress.
- The plan prioritizes urgent surgeries; patients who had their surgery postponed and have been waiting over twice their clinical benchmark; day surgeries; and maximizing surgeries that can be performed outside of operating rooms.
- During the initial COVID-19 response, surgeries were taking approximately 26% longer to complete due to a necessary increase in infection prevention controls. By the June 26 to July 23, 2020, reporting period, surgical efficiency returned to approximately pre-COVID-19 levels[6].
- HAs originally planned to add 16% more surgical capacity (operating room hours) from June 15, 2020, to March 3, 2021, annualizing to a 24% gain in 2021/22[7]. Based on those plans, all HAs were projected to catch-up to postponed surgeries by the end of 2021. These plans were impacted by the subsequent waves of COVID-19.
- For Fiscal Year 2020/21 (Year 1 of Surgical Renewal) [8]:
    - Total surgical volumes were 316,276, a decrease of 4.3% since 2019/20 and an increase of 0.3% since 2016/17 levels, despite significant impacts of the pandemic in 2020.
    - Total scheduled surgical volumes were 236,089, a decrease of 5.0% since 2019/20 and an increase of 1.1% since 2016/17 levels.
    - Total urgent scheduled surgical volumes were 49,584, an increase of 1.7% since 2019/20 and an increase of 5.6% since 2016/17 levels.
    - Total non-urgent scheduled surgical volumes were 185,821, a decrease of 6.6% since 2019/20 and an increase of 0.3% since 2016/17 levels.
- For Fiscal Year 2021/22 (Year 2 of Surgical Renewal) [9]:
    - Total surgical volumes were 337,560, an increase of 2.2% since 2019/20 and an increase of 7.1% since 2016/17 levels.
    - Total scheduled surgical volumes were 254,660, an increase of 2.5% since 2019/20 and an increase of 9.1% since 2016/17 levels.

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[5] BC Gov News. (September 9, 2020). Investment brings new support to those most vulnerable to COVID-19 and communities where they live. Retrieved from: https://news.gov.bc.ca/releases/2020PREM0050-001694

[6] BC Gov News. (September 1, 2020). B.C progresses on surgical renewal plan. Retrieved from: https://news.gov.bc.ca/releases/2020HLTH0049-001627 Progress Report 2 https://news.gov.bc.ca/files/2020_surgical-renewal-commitment-progress-report-June-July-2020.pdf

[7] BC Gov News. (January 6, 2021). Adding surgeries for patients: Catching up from COVID-19. Retrieved from: http://news.gov.bc.ca/releases/2021HLTH0003-000011 Progress Report #3 https://news.gov.bc.ca/files/SurgicalRenewalReport3.pdf

[8] Source: Health Sector Information Analysis & Reporting, CCS Branch; Surgical Wait Times (SWT) RMS 2627 HSA 2022-23 Estimates Surgical, GI Endo, MI Site 297. Restated data.

[9] Source: Health Sector Information Analysis & Reporting, CCS Branch; Surgical Wait Times (SWT) RMS 2627 HSA 2022-23 Estimates Surgical, GI Endo, MI Site 297. Restated data.

- Total urgent scheduled surgical volumes were 52,216, an increase of 7.1% since 2019/20 and an increase of 11.3% since 2016/17 levels.
- Total non-urgent scheduled surgical volumes were 201,880, an increase of 1.5% since 2019/20 and an increase of 9.0% since 2016/17 levels.
- In August 2021, HAs met their goal of providing 400 additional surgical specialty nurse training seats.
- The Ministry and HAs have also met their goal of training 100 medical device reprocessing technicians and continue to ramp up training.

LAST UPDATED

The content of this fact sheet is current as of [INSERT DATE OF EAPP APPROVAL] as confirmed by Shana Ooms.

APPROVALS

2023 02 15 – Kristy Anderson, Hospital and Provincial Health Services Division
2023 02 21 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 28 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Access to Psychiatric Services

Topic: Access to psychiatry in BC.

Key Messaging and Recommended Response:

- **Our government is making historic investments to improve access to mental health supports, so that when people ask for help, help is available.**
- **Access to psychiatrists can make a profound impact on the lives of individuals, families, and communities by empowering people to lead healthy and fulfilling lives.**
- **Psychiatrists operate in various settings including in private practice (private pay and/or funded by MSP Fee for Service), in hospitals, and in publicly funded Mental Health and Substance Use programs operated by health authorities such as Adult Community Support Services, Adult Short-Term Assessment and Treatment Services, Assertive Community Treatment, Early Psychosis Intervention, and Eating Disorder programs.**
- **Psychiatrists can be accessed via a referral from an emergency room doctor in a hospital. In non-emergency situations patients generally require a referral from a family doctor.**
- **The health authorities enable access to psychiatry services for children, youth, and adults through primary care, community mental health centres, and Foundry Centres, in addition to urgent, acute, and tertiary in-patient/outpatient care. MCFD delivers psychiatry supports to young people through community-based mental health services.**
- **Expanding access to mental health and substance use services continues to be a priority for our government.**
- **Since we formed government, we've been improving access to low or no-cost mental health and substance use care – virtually and in-person - through different initiatives, like Foundry centres, Integrated Child & Youth Teams and new Urgent and Primary Care Centres.**
- **We know there is more to do and we are working hard to make sure when people make the brave decision to come forward for help, supports and services are there to meet them.**

CURRENT SITUATION

- Access to psychiatrists varies throughout BC and wait times can range from one day to one year depending on location, type of program, and level of acuity of a patient's condition.
- Psychiatrists work in various settings including in private practice (through private pay and through MSP Fee for Service), in hospitals, and in publicly funded mental health and substance use (MHSU) programs operated by Health Authorities such as Adult Community Support Services, Adult Short-Term Assessment and Treatment Services, Assertive Community Treatment, Early Psychosis Intervention, and Eating Disorder programs.
- Child and youth mental health services have multiple points of entry. The Ministry of Children and Family Development (MCFD) has the primary mandate to deliver community-based mental health services for children and youth including psychiatry supports. In 2021/22, 72 psychiatrists were contracted with MCFD, and 3198 psychiatric consultation sessionals were provided.[1]
- MCFD also delivers Youth Forensic Psychiatric Services providing court-mandated forensic assessments and interventions to youth involved in the justice system and support youth who are on community or custody supervision via:
  - in-Patient Assessment Unit in Burnaby
  - outpatient clinics in Vancouver, Burnaby, Langley, Victoria, Nanaimo, Prince George, Kamloops, and Kelowna.[2]
- The health authorities enable access to psychiatric services for children and youth through community mental health centres and Foundry Centres, in addition to urgent, acute, and tertiary in-patient/outpatient MHSU care.
- Some psychiatrists providing services to children and youth operate within a private practice model, including some MSP Fee for Services, while others are integrated within publicly funded MHSU programs operated by health authorities and/or MCFD.
- In emergency circumstances psychiatrists can be accessed via a referral from an emergency room doctor in a hospital. In non-emergency situations patients generally require a referral from a family doctor or nurse practitioner[3].
- In 2021/22, a total of 859 psychiatrists received BC MSP[4] fee-for-service payments for patient care.

Fraser Health Authority (FHA)

- Most urgent psychiatric care, other than emergency department care, is delivered via Rapid Access Clinics, which are accessed via referral from a family doctor. They provide quick access to a psychiatrist and nurse from a MHSU Centre. The psychiatrist provides diagnoses, treatment, and follow-up recommendations to a family doctor or nurse practitioner.
- Specialized psychiatric services such as reproductive psychiatry, early psychosis intervention, group psychotherapy are also available through family doctor referrals.
- Wait times vary depending on location and severity of symptoms. Wait times for initial psychiatrist assessments in most community MH teams vary from 6 weeks to 6 months and for initial assessments for patients referred by family and ER physicians there are sites where waits are 9 months or longer.[5]
- There are 144 psychiatrists who hold contracts with FHA; many are part-time and several work in other HAs. There are 7 FTE child and youth (CY) psychiatrists supporting the entire region.[6]
- There is currently need for 124 psychiatrists across FHA in hospital care, community mental health team care, and community-based private psychiatric care to serve family physicians seeking consultation and follow-up for those with mild to moderate MHSU needs.[7]

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[1] Pawar, D. (2023). Email communication from MCFD on April 4, 2023.
[2] MCFD (2023). 4.1 Overview of CYMH. Estimate note shared by Deborah Pawar, April 4, 2023.
[3] BC College of Nurses and Midwives NP Scope of Practice. April 4th, 2023. https://www.bccnm.ca/NP/ScopePractice/part2/Pages/consult_refer.aspx
4 B.C. Ministry of Health. Health Sector Information, Analysis, & Reporting Division. MSP Information Resource Manual (IRM) Fee-For-Service Payment Statistics 2021/2022. Table 1.1. *https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_information_resource_manual_**20212022**.pdf*
[5] Koo, A. (2023). Email communication re information on psychiatry from FHA on April 4, 2023.
[6] Ibid.
[7] Ibid.

Island Health Authority (VIHA)[8]

- Access to psychiatrists usually occurs via referrals from primary care or acute care, though in some areas primary care refers clients to MHSU support teams who decide if a psychiatric referral is required. All referrals come through the local Intake Team, where triaging determines who is best fit for the referred client.
- In all Local Health Areas, clients can self refer to MHSU services and request a psychiatric referral. They would see a walk-in counsellor, where it would be determined if a psychiatric referral is required. If the client does not have a primary care provider, they would help clients access primary care referrals which are needed to access psychiatry services. If they have a primary care provider, the client would need to see their provider who would then send a referral to see a psychiatrist.
- Some regions use a shared care system where psychiatrists provide recommendations for recovery and return a patient to their family doctor for monitoring and follow-up. Depending on client acuity, once a psychiatry consult has occurred, many clients can be managed by their primary care provider. It isn't possible for psychiatrist to manage all clients with MH concerns, as they would have no capacity to see new clients.
- Non-urgent wait times to access a psychiatrist range from one week to one year.
- Most regions have systems in place to fast-track referrals submitted by a primary care provider to psychiatrists based on client needs.
- Psychiatric Emergency Services at Royal Jubilee Hospital in Victoria and Nanaimo Regional General Hospital provide 24/7 specialized emergency psychiatric and substance use care to adults (17-75 years) experiencing emergent MHSU crises.
- As of April 2023, there are 56.2 FTE filled and 20.4 FTE vacant psychiatry positions. There are 12.3 FTE CY psychiatrists, however only 9.4 FTE filled and 2.9 FTE vacant. There are 15.9 FTE geriatric psychiatrists with 13.9 FTE filled and 2 FTE vacant.

Vancouver Coastal Health Authority (VCHA)[9]

- Clients with psychiatric concerns are triaged through a central intake system depending on clinical urgency.
- A clinical intake assessment is conducted by a master's level mental health clinician who uses applicable risk assessment screens such as overdose risk assessment, suicide risk assessment, medication side effects, etc.
- For clients deemed low risk, average wait time is three weeks to about three months. High risk/urgent cases can access assessment via referral to mobile assessment through Fox 80 in Richmond, Car 87/88 in Vancouver, and Fox 22 on the North Shore.
- Acute Home Based Treatment provides urgent access to acute psychiatry and nursing at home for voluntary clients in Richmond.
- In Vancouver, the Access and Assessment Centre (AAC) provides support for non-life-threatening MHSU concerns. Staff include registered nurses, registered psychiatric nurses, social workers, and psychiatrists.
- As of February 2023, there are 171.9 FTE psychiatrists practicing in VCHA. There are 21 psychiatrists delivering 10.4 FTE CY psychiatriatric services at VCHA, including 3FTEs at BC Children's Hospital that support CY psychiatry in VCHA.
- As of April 2023, there are 18 vacant psychiatry positions in VCHA.[10]

Interior Health Authority (IHA)

- The standard process for referral to a psychiatrist is for family doctors to send a referral to their local MHSU office. Referrals are reviewed and prioritized based on urgency.
- Wait times across the region can range from one week up to a year, with an average wait time of 70 days in 2022. While waiting for an appointment, clients are supported by community mental health services.

[8] Leadbetter, S (2023) VIHA Email Communication re Information on psychiatry received April 11, 2023.
[9] Welsh, K. (2023). Email communication re information on psychiatry (1) from VCHA on Apr 5, 2023
[10] Welsh, K. (2023). Email communication re information on psychiatry from VCHA on Apr 5, 2023.

- As of February 2023, IHA has 59 active/provisional providers with psychiatry privileges,[11] There are currently 6.25 CY psychiatrist FTEs[12]
- There are 36 vacant FTEs for psychiatry, including 10 vacant FTEs specific to CY psychiatry.

Northern Health Authority (NHA)

- As of February 2023, there are 20 psychiatrists practicing in NHA and support is also available via tele-health appointments from psychiatrists who live in other parts of the province.[13]
- Wait times are approximately 3-6 months with access to urgent assessment in some areas in under 2 weeks.
- Generally, family physicians refer clients to interprofessional teams or direct to psychiatry.
- Support from interprofessional teams is often available while clients await psychiatry.
- Currently, there are no CY Psychiatrist in NHA other than through the BC Children's Hospital on call services and through the Compass progam.
- There are 9 posting for psychiatrists: 2 general psychiatry (Dawson Creek), 3 adult psychiatrists (Terrace & Prince Rupert), and 2 child and youth psychiatrists (Prince George).[14]

BC Children's Hospital (BCCH)[15]

- Psychiatrists are involved in most clinical, educational, research and administrative aspects of the Provincial Child, Youth and Young Adult Mental Health and Substance Use Program at BCCH.
- Often as members of interdisciplinary teams, psychiatrists provide both direct and indirect (e.g., supporting family physicians and paediatricians in the community, or supervising learners) clinical assessment, consultation and treatment on outpatient, inpatient, emergency room and day treatment programs.
- Most psychiatrists are compensated through a "blended billing" model, which combines MSP fee-for-service and sessional support, while a few programs support psychiatric care through service contracts (e.g., Compass and the Youth Substance Use service known as SURF).
- BCCH's Compass program is a province-wide interdisciplinary service that supports evidence-based care for all children and youth in BC and the Yukon living with MHSU concerns, including telepsychiatry consultation, and continues to pilote a project with NHA of direct assessments for CY patients accessing the rural and remote emergency departments.
- There are 37 psychiatrists under contract with BCCH and a 0.4 FTE vacancy for the Child and Adolescent Psychiatric Emergency (CAPE) program.

FINANCIAL IMPLICATIONS

Psychiatrists billed for $192.24 million fee for service work for fiscal year 2021/22 as of September 30, 2022. [4]

KEY BACKGROUND

Psychiatry Education, Training, and Recruitment in BC

- The University of BC (UBC) has the only Faculty of Medicine in BC.
- In BC and the rest of Canada, medical education is a 2-step process:
    - Doctor of Medicine (MD) Undergraduate Degree – A 4-year long program, offered at 4 university campuses and at hospitals, clinics and in community settings throughout BC
    - Residency Training – UBC's psychiatry residency is a 5-year program accredited by the Royal College of Physicians and Surgeons of Canada
- Entry-level Psychiatry residency positions at UBC have been expanded from 22 total positions in 2018/19 to 26 projected total positions in 2022/23.[16]
- Recruitment strategies across Health Authorities include advertising on Health Match and Better Here, attending psychiatry conferences in Canada and internationally, outreach to recruit residents into

[11] Morris, D. (2023). Email communication from IHA received on Feb. 23, 2021.
[12] Morris, D. (2023). Email communication re information on psychiatry from IHA received on April 5, 2023.
[13] Lawrence, M. (2021). Email communication from NHA on Feb, 23, 2023.
[14] Lawrence, M. (2023). Email communication re information on psychiatry (3) from NHA on April 6, 2023.
[15] Burke, S. (2023). Email communication re information on psychiatry from BCCH on April 5, 2023.
[16] Feraru, Loredana. (2022) Senior Policy Analyst, Physician Workforce Development Branch. Email communication. April 12, 2022.

psychiatrist positions during their training in BC and from other provinces, international recruitment (3 recent hires in FHA from the US), recruiting family physicians with an interest in psychiatry to work in community mental health settings, and placing return of service residents in underserved communities.

Re-entry In Psychiatry[17]

- In July 2022, the Ministry directed funding to implement a new 'Re-entry into Residency' psychiatry position, providing an accelerated education pathway for licensed physicians to re-train in psychiatry in exchange for a return of service commitment upon training completion.
- This July 2022 re-entry psychiatry position further supported introduction of a net new UBC Department of Psychiatry training site in the Interior Health Authority.
- Effective July 2023, the Ministry further increased the re-entry in psychiatry from 1 to 2 positions with a return of service contract upon training completion.

LAST UPDATED

The content of this fact sheet is current as of April 5, 2023, as confirmed by Gerrit van der Leer, Acting Executive Director, Mental Health and Substance Use Division.

APPROVALS

2023 03 13 – Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 13 – Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2023 04 12 – Darryl Sturtevant, Mental Health and Addiction Division

[17] Feraru, Loredana. (2023) Senior Policy Analyst, Physician Workforce Development Branch. Email communication. March 22, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

East Hastings Encampment Response

Topic: Overview of the Province's response to Vancouver's East Hastings encampment.

Key Messaging and Recommended Response:

- **Everyone in the Downtown Eastside deserves a safe, stable and supportive place to call home.**
- **Over the past several months, the Province has led work with Indigenous, community and government partners to develop and implement a new coordinated response plan to support people in the Downtown Eastside and build on the community's strength and resilience.**
- **It's focused on helping people get off the streets and into homes to resolve encampments, and on strengthening health, social and cultural supports to make the Downtown Eastside a healthier, safer place for everyone.**
- **One of the key measures of the response plan is strengthening access and co-ordination for health, mental-health and substance use services for people in the Downtown Eastside, including through:**
    - **establishing a new multidisciplinary team that will work to identify the needs of people facing homelessness so they can quickly access health and social services and support transitions to indoor spaces as a pathway to appropriate housing options;**
    - **expanded addiction treatment options, such as the new Road to Recovery model of addictions care at St. Paul's Hospital; the first 45 beds are expected to open by fall 2023; and**
    - **expanded mental-health crisis response teams.**

CURRENT SITUATION

- On July 25, 2022, Vancouver Fire and Rescue Services issued a Fire Order to remove tents and structures along East Hastings Street due to imminent structure and life safety dangers. The City of Vancouver (CoV) developed a phased Hastings Structure Removal plan that commenced on August 9, 2022. This plan, which was quickly halted and paused until January 2023 when CoV resumed activities with a measured approach to provide clean-up, storage and outreach.
- In September 2022, A Provincial Executive Steering Committee (PESC), led by AG, was established to provide oversight of the planning and implementation of the encampment response. This committee includes executive representatives from CoV (fire, police, and CoV), BC Housing, Ministry of Health (HLTH), Ministry of Social Development and Poverty Reduction (SDPR), Emergency Management BC, Ministry of

Public Safety and Solicitor General, Ministry of Mental Health and Addictions (MMHA) and Vancouver Coastal Health Authority (VCHA).

- To enhance cross sectoral demographic data on the population residing on Hastings, VCHA conducted an informal mapping exercise in early October 2022 to assess attachment to health services and level of wellness in the DTES. Key findings include[1]:
  - ~60% of the 180 people surveyed were attached to a clinic/health team.
  - ~60% assessed as having low health needs, 30% as medium, and 5% as high.
  - Hastings blocks generally had higher acuity and lower attachment.
- HLTH has been supporting VCHA to provide community members impacted by the structure removal with health care and other supports, including [2]:
  - Access to 6 existing Assertive Community Treatment teams in the Vancouver area;
  - provision of harm reduction supplies and overdose response training to encampment residents;
  - surveillance with partners for evidence of increased overdoses;
  - health and wellness checks during declared heat warnings;
  - periodic walk throughs to check in on clients and connect them to primary and addictions care;
  - and periodic inspections by Environmental Health Officers to monitor provision of safe drinking water, sanitation, and food services.
- Since the Fire Order was first issued in late July 2022, BC Housing has opened 139 spaces in Vancouver, which is a combination of recently renovated single room occupancy hotel rooms and new shelter spaces.**Error! Bookmark not defined.**
- Under a renewed 2022 mandate, the Ministry of Health (the Ministry) continues to work with the Ministries of Housing (HOUS), the Attorney General (AG), Mental Health and Addiction (MMHA), Social Development and Poverty Reduction (SDPR), Public Safety and Solicitor General (PSSG), Children and Family Development (MCFD), and Indigenous Relations and Reconciliation (MIRR) as well as with BC Housing, health authorities (HAs) and Indigenous Partners to address the needs of people experiencing homelessness, including those living in encampments.
- Since the refreshed mandate, the province has led the development of a draft *Provincial Response Plan: Supporting the Downtown Eastside* (the Plan). Announcement of the Plan is anticipated in March 2023.
- The Plan outlines the provincial government's approach to restoring community health and safety in the DTES, as well as the prevention of encampments in the DTES from growing and becoming entrenched long-term.
- On February 14, 2023, CoV approved the proposal from VCHA for a $2.8M grant to enhance urgent mental health services, including expanding the Car 87/88 program, establishing moderate de-escalation services, and strengthening Indigenous approaches across all VCHA Urgent and Mental Health and Substance Use services. Grant funding was enabled by the Council motion to hire 100 new police officers and nurses.[3,4]
- To expand housing options for the decampment of Hastings, VCHA will be submitting a proposal to provide enhanced health supports to the temporary modular units with expected tenancy beginning in March 2023.
- The request for proposal was endorsed by PESC and will be supported through early investments in the implementation of the Homelessness Strategy, Integrated Support Framework for supportive housing units through Budget 2023.
- A January 2023, CoV outreach summary showed that 92 people sheltering along Hastings Street need housing, 69 of whom have been sheltering there for at least five months. As of January 24th; 77 structures remained along Hastings St., the lowest amount since reporting began with more than 180 in August 2022.[5]

[1] Ministry of Attorney General and Minister Responsible for Housing. (October 18, 2022). East Hasting Encampment Response Issues Note.
[2] Email communication from VCH. September 20, 2022
[3] CoV (accessed Feb 17, 2023). Council receives proposal to expand collaborative partnerships on mental health and public safety in Vancouver.
[4] CoV Meeting Minutes – Council meeting – February 14, 2023. https://council.vancouver.ca/20230214/documents/regu20230214mins.pdf
[5] Ministry of Housing (February 10, 2023). East Hasting Encampment Response Issues Note.

FINANCIAL IMPLICATIONS

- In 2020/21, HLTH provided $2.263M to VCHA to reimburse costs incurred to support the decampment initiatives related to Oppenheimer Park in Vancouver.
- In 2021/22, HLTH allocated $13.04M to VCHA to support urgent homelessness and decampment initiatives.
- In 2022/23, HLTH allocated $18.12M to VCHA to support ongoing urgent homelessness and decampment initiatives, and $2.5M for the Supported Rent Supplement Program.
- Budget 2023 provides $228 million over three years to establish new regional multi-disciplinary teams to support rapid response for regions responding to substantive encampments.

KEY BACKGROUND

- In January 2023, the province approved a refreshed Homelessness Strategy, *Belonging in BC* (the Strategy), that sets a framework for government's actions to address homelessness, with a move towards a greater focus on prevention and stability as well as immediate response.
- Health needs in the Vancouver Downtown Eastside (DTES) are complex, with the client population experiencing mental health & substance use challenges, history of trauma, and Indigenous-specific issues.[6]
- With Urgent Homelessness Response and decampment funding, VCHA implemented health, and mental health and substance use services to support individuals moving from encampments into indoor spaces in Vancouver, including low barrier home support, outreach mental health and substance use, and primary care for homeless and newly housed individuals, intensive housing outreach teams, inner city Public Health Outreach to homeless/precariously housed, and housing-based overdose prevention.
- A new report from the Office of the Federal Housing Advocate says that Canada's approach to homeless encampments is a human rights violation and that Vancouver's response to the increasing encampments has led to serious harm and lawsuits, adding that tearing down encampments amount to forced eviction.[7]

LAST UPDATED

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APPROVALS

2023 02 21– Gerrit van der Leer, Mental Health and Substance Use Division
2023 03 31 – Darryl Sturtevant, Mental Health and Addictions Division
2023 03 21 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[6] Vancouver Coastal Health. (December 12, 2022). Proposed Framework for Vancouver Inner City MHSU Supports.
[7] Flynn, A. et al. 2022. Overview of Encampments Across Canada: A Right to Housing Approach. The Office of the Federal Housing Advocate.

LEGISLATIVE SESSION – ESTIMATES NOTE

Mental Health Act

Topic: The *Mental Health Act* (the Act) outlines the legislative requirements for involuntary care for individuals with severe mental disorders and designated facilities under the Act. The main purpose of the Act is to provide authority, criteria and procedures for involuntary admission and treatment of mental disorders, while safeguarding individuals' rights.

Key Messaging and Recommended Response:

- **Nothing is more important than keeping people safe and ensuring people are treated with dignity and respect.**
- **We know that there are situations when someone is experiencing a mental health emergency where involuntary admissions under the Mental Health Act can be necessary to protect health and save lives.**
- **We understand the gravity of these situations and take seriously the need to balance the rights of the individual with our obligation to help and protect people living with mental illness.**
- **It is always necessary to ensure that legislation is meeting the needs of people in BC. We regularly receive suggestions to improve the Mental Health Act and are in the early stages of reviewing sections of the Act.**
- **While we know the Mental Health Act is vital in certain situations to save lives, we also know that voluntary services are the most effective, when possible.**
- **Through Budget 2023, we are making historic investments into treatment, prevention and early childhood initiatives to prevent small challenges from becoming more severe later in life.**
- **Providing access to quality care, balanced with the need for a voluntary continuum of services and respect for people's choices continues to be a primary focus for our work.**

CURRENT SITUATION

- In June 2017, the Office of Ombudsperson (OoO) conducted a review of involuntary admissions under the Act within 39 designated facilities. The review focused primarily on the requisite completion of the *Mental Health Act* forms, according to the Act Regulations, and education of staff in designated mental health facilities including education regarding the role of the appointed Act Directors.

- In March 2019, the OoO released the report: *Committed to Change: Protecting the Rights of Involuntary Patients Under the Mental Health Act,* which contained 24 recommendations for implementation by the Ministries of Health (HLTH), Mental Health and Addictions (MMHA), and the Ministry of Attorney General (MAG), as well as provincial and regional health authorities.
- The Ministry's progress to date includes:
    - Provincial *Mental Health Act* standards were developed and endorsed by a provincial advisory committee comprised of senior representatives of health authorities, MCFD, CLBC, MMHA and the First Nation Health Authority. The Ministry approved the standards in October 2020 which were released on December 9, 2020.
        - Quantitative and qualitative provincial audit measures for the completion of the *Mental Health Act* forms are included in the provincial *Mental Health Act* standards. Since 2019 quarterly audits are undertaken by Health Authorities of each designated facility to measure improvements in form completion.
    - An update of the provincial guide to the Act is underway and expected to be released in the fall of 2023.
- The OoO released a follow-up to their 2019 report in the Spring of 2022. While the Ombudsperson acknowledged the work done to date, they also indicated that further improvement is needed in compliance and additional work is necessary to meet recommendations related to rights advice.
- In spring 2022 government introduced legislation to establish a province-wide independent rights advice service for all patients who are involuntarily admitted to designated facilities under the Act, including patients under 16 admitted by a parent or guardian and those patients discharged from the designated mental health facility on Extended Leave provisions under the Act. The legislation received Royal Assent on June 2, 2022.
- The role of the rights advice service will be to explain rights and options available under the MHA, assist individuals to exercise these rights, and refer individuals to a lawyer or advocate if a court hearing or Mental Health Review Board hearing is requested. The service will be primarily virtual, using videoconferencing and phone, with some in-person services available in certain circumstances.
- The service is anticipated to begin rolling out on an on-request basis in the fall of 2023, and automatic notification of the rights advice service at key points is expected to start in the second phase of implementation.
- In February 2023 sections 9-12 of the *Nurse Practitioners Statutes Amendment Act, 2011* was brought into force to enable nurse practitioners to complete medical certificates under the *Mental Health Act* for purposes of voluntary and involuntary admission of individuals to designated mental health facilities. This permits nurse practitioners to conduct examinations and complete medical certificates for involuntary admission of individuals with severe mental disorders into designated facilities for the initial 48-hour period (i.e., the first medical certificate). This would also allow them to complete medical certificates for purposes of sections 28 (involuntary admission following police apprehension) and section 29 (transfer from a correctional facility to a provincial mental health facility).

FINANCIAL IMPLICATIONS

Legal Information

KEY BACKGROUND

- The Act was last updated in 2005.
- 76 Facilities are designated under the Act, as of February 2023, including:
    - 25 Provincial mental health facilities, providing specialized inpatient treatment, tertiary care, and/or treatment of sub-populations such as forensic clients;
    - 37 Psychiatric Units located in acute care hospitals, providing inpatient treatment; and

- 14 Observation Units in rural hospitals, providing short stay for stabilization and/or transfer.[1]

- In 2021/22, 30,922 inpatients were treated within acute care facilities or selected tertiary care facilities for mental illness and/or substance use challenges as the most responsible diagnosis for their hospital stay.
- An additional 31,030 patients received treatment for mental illness and/or substance use challenges during hospital stays where the most responsible diagnosis was another condition. These additional patients were not previously included in reporting but have been added to provide complete information on mental health and substance use hospitalizations.
- The total number of patients treated for mental illness and/or substance use challenges was 61,952. This total was an increase of approximately 8% over 2020/21 (57,504 patients) and an increase of 33% over 2012/13 (46,532patients)[2].
- In 2021/22, 19,974 patients received involuntary mental health treatment. Of these, 89% had mental health and/or substance use challenges as the most responsible diagnosis for their hospital stay (17,968 patients with involuntary status) and 8% received treatment for mental illness and/or substance use challenges during hospital stays where the most responsible diagnosis was another condition (1,615 patients with involuntary status). The remaining 391 patients received involuntary care, though abstraction of patient diagnosis did not include a specific mental health diagnosis, rather external causes such as self-harm were common[2].
- A patient can only be involuntarily admitted under the Act if the following criteria are met:
    a) Suffer from a mental disorder that seriously impairs their ability to react appropriately to their environment, or to associate with others.
    b) require psychiatric treatment in or through a designated facility.
    c) require care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration, or for their own protection or the protection of others; and
    d) are not suitable as a voluntary patient.
- To provide legal authority for an involuntary admission for an initial 48-hour period, a medical certificate must be completed by a physician. The completed medical certificate provides authority to take the person to a designated mental health facility. A second medical certificate by a different physician must be completed within 48 hours of admission; otherwise the patient must be discharged or admitted as a voluntary patient. Medical certificates must be renewed by the end of the first, second and fifth months of admission, and at subsequent 6-month intervals.
- Section 37 of the Act permits the director of the designated mental health facility to place an involuntary patient on Extended Leave from the facility. Leave means that a patient is authorized to be absent from the facility to live in the community, providing appropriate support services exist to meet the conditions of Extended Leave.
- The Act also includes protections to ensure the provisions are applied in an appropriate and lawful manner. For example, hospital staff must inform involuntary patients verbally, and also provide subsequent written notification, of their rights promptly upon admission.
- The Mental Health Review Board is an independent, quasi-judicial administrative tribunal established in 2005, which conducts review panel hearings under the Act upon client request.

- Legal Information

[1] Designations under the *Mental Health Act*. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2018/facilities-designated-mental-health-act.pdf., Accessed February 21, 2019.
[2] Mental Health Hospitalizations in BC, Involuntary Under the Mental Health Act (MHA) and Other Legal Status. PAS #3000-0220 CROSS MH Act Involuntary Voluntary Care; Health System Information, Analysis and Reporting Division. Data provided February 2022. Note that comparisons to 2019/20 data cannot be made for legal status data due to changes in data collection methodology for DAD.

Legal Information

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APPROVALS

2023 02 22 – Darryl Sturtevant, Mental Health and Additions Division
2023 02 23 – Gerrit van der Leer, Mental Health and Addiction Division
2023 02 26 – Eric Larson obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 09 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Overview of Mental Health and Substance Use Services

Topic: Overview of mental health and substance use (MHSU) services in BC.

Key Messaging and Recommended Response:

- **We've been through a lot as British Columbians, from the ongoing COVID-19 pandemic, the toxic drug crisis, climate related challenges and the findings of unmarked graves on the grounds of former residential school sites.**
- **And through two concurrent health emergencies, we have never asked as much from our health authorities and front-line workers.**
- **Young people are seeking support for mental health concerns, such as eating disorders and anxiety at unprecedented rates**
- **Highly toxic and unpredictable illicit drugs are everywhere and far too many people are at risk of fatal toxic drug poisoning.**
- **The number of people who died from the toxic drug supply is tragic. We must do more to prevent this tragic loss of life.**
- **Our government is making historic investments to improve access to mental health supports, so that when people ask for help, help is available.**
- **Budget 2023 invests one billion dollars to expand services across the continuum of care.**
- **Our government is transforming mental health and substance use services in the province, including enhancements across the full spectrum of treatment and recovery and increasing access to harm reduction measures, like drug checking.**

CURRENT SITUATION

- The COVID-19 pandemic has impacted all aspects of health care, including MHSU services and compounded the challenges associated with BC's ongoing illicit drug toxicity crisis.
- There were 2,272 suspected illicit drug toxicity deaths in 2022, the second largest number of suspected deaths ever recorded, behind 2021 (2, 306).[1]
- Current, data reported by the Ministry of Health through MSHU Service - Health System Performance Portal Report [2], indicates that the number of mental health and substance use clients in BC has increased from 179 per 1,000 population to 186 per 1,000 population between FY 2021/22 and FY 2020/21.

[1] BC Coroners Service. (2022). Illicit Drug Toxicity Deaths in BC January 1, 2012 – December 31, 2022. Retrieved February 16, 2023 from https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

[2] Ministry of Health Health Systems Performance Portal Embargoed version: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/embargo-mental-health-substance-use-service, retrived on March 10, 2023 at 10:00.

- All health authorities (HAs) report increasing, year over year demand resulting in higher caseloads, wait times, waitlists for service, particularly for services that support the needs of complex individuals.[3] Vulnerable populations, including those experiencing homelessness, have been increasing in BC impacting demands on services (see Homelessness and Encampment Fact Sheet for additional information).

FINANCIAL IMPLICATIONS

- The Ministry funded approximately $2.066 billion on MHSU in 2021/22 to HA operated services as well as partner organizations to support MHSU across the following subsectors: acute and tertiary MHSU services, community-based MHSU, physician services, pharmacare, health prevention and promotion activities, and targeted initiative funding.
- Of this, HAs reported expenditures of $1.394 billion in 2020/21 and $1.476 billion in 2021/22 for the MHSU sector

KEY BACKGROUND

- In 2021/22, 1,011,405 unique individuals in BC received treatment from Ministry funded services because of MHSU conditions[4]. Of these individuals, more than 112,092 individuals[5] were reported in MHA Minimum Reporting Requirements (MHA MRR) receiving MH or SU services from facilities owned and operated by the regional health authorities (e.g. case management services).
- 163,512 community visits for MHSU conditions were reported in MSHU Service - Health System Performance Portal Report[6] for fiscal year 2021/22.
- 44,972 hospital stays related to MHSU conditions were reported in MHSU Service – Health System Performance Portal Report[6] for Fiscal Year 2021/22.
- The most commonly reported mental health conditions in BC are anxiety and depression. To address the need of people with MHSU disorders, the Ministry of Health provides the following core MHSU services for children, youth and adults.

Inpatient Acute Care and Tertiary Care Services, including:

- Hospital inpatient psychiatric services, such as Psychiatric Emergency Units.
- Observation Units in rural hospitals.
- Specialized inpatient psychiatric units.
- Specialized MHSU Tertiary Care Units which provide specialized assessments, treatment and rehabilitation services for people with complex MHSU disorders.
- Tertiary eating disorders services.
- Hospital outpatient psychiatric services.
- Neuropsychiatry services.
- Psychogeriatric services.
- Forensic Psychiatric services.
- Correctional MHSU services in custody services.

[3] As reflected in requested health authority utilization data to inform system planning in 2022

[4] Ministry of Health. RMS 2450. Mental Health & Substance Use Report Embargoed version: https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/embargo-mental-health-substance-use-service, retrived on March 10, 2023 at 10:00

[5] MHA MRR data extracted on March 10, 2023.Government Financial Information; Security Concern
Government Financial Information; Security Concern

[6] Ministry of Health Health Systems Performance Portal Embargoed version. : https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/embargo-mental-health-substance-use-service, retrived on March 10, 2023 at 10:00

Community-based MHSU Services, including but not limited to:

Mental Health	Substance Use
○ Crisis Intervention services such as crisis lines, mobile crisis outreach, crisis stabilization units ○ Clinical Case Management services, including psychiatric assessment, treatment and rehabilitation ○ Mental health Home Treatment services and support linked with acute care psychiatric services ○ Community Forensic Clinical services ○ Assertive Community Treatment teams ○ Early Psychosis Intervention services ○ Community Eating Disorders Services ○ Counselling services such as Cognitive Behavioral Interventions (CBT) ○ 24 hour staff licensed mental health residential care facilities ○ Mental health supported housing units ○ Psychosocial rehabilitation services, providing supported employment and supported education services, Club Houses, wellness support services addressing nutrition and exercise ○ Elderly community MHSU assessment and treatment services including assessment and support services for people with early signs of dementia ○ Peer and Family Support ○ Integrated Child and Youth Teams	○ Withdrawal management services, including home detox withdrawal management ○ Substance use community-based outpatient care ○ Intensive Case Management Teams (ICMTs), which are community outreach-based model of wrap-around service provision for individuals and their families, impacted by complex, severe substance use ○ Community substance use treatment/care beds, including supportive recovery, transitional services, medically supervised withdrawal management, and beds for sobering and assessment ○ Overdose Prevention Sites, injection and inhalation ○ Drug checking ○ Safer supply distribution and prescribing ○ Opioid Agonist Treatment (OAT) and Injectable OAT clinics ○ Risk mitigation prescribing ○ Peer and Family Support ○ Youth Concurrent Disorders inpatient treatment ○ Proactive Outreach[7]

Physician Services, including:

- Shared care MHSU services integrated with community clinical MHSU case management services.
- Primary care networks where physician with support from allied health clinicians such as social workers and nurses that provide MHSU assessment, treatment and follow up.
- Access Centres providing clinical MHSU assessment for people with high levels of MHSU acuity.
- Medication-assisted treatments, such as opioid agonist treatment, and pharmaceutical alternatives to the illicit toxic drug supply.

Health Prevention and Promotion including:

- Suicide Prevention services.
- Perinatal MHSU services.
- MHSU Health Literacy such as the provincial HeretoHelp.bc.ca website.
- Harm Reduction and Overdose Prevention Services, including drug checking.

LAST UPDATED

The content of this fact sheet is current as of February 21, 2023 as confirmed by Gerrit van der Leer, Acting Executive Director, Mental Health and Substance Use Division.

APPROVALS

2023 02 21 – Gerrit van der Leer, Mental Health and Substance Use Division
2023 03 04 – Darryl Sturtevant, Mental Health and Addiction Division
2023 03 13 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03 25 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[7] New announcement in Budget 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

Provincial Homelessness – Mental Health and Substance Use Supports

Topic: Overview of the Province's response to homelessness and encampments with a focus on wraparound mental health and substance use (MHSU) supports and services.

Key Messaging and Recommended Response:

- **Homelessness is growing in BC, made worse by the housing affordability and drug toxicity crises.**
- **In Budget 2023, government committed $272M over 3 years to build on the additional measure to address homelessness announced in Budget 2022, including additional housing and health supports for vulnerable people, and new teams and new housing units to address the needs of people living in encampments.**
- **In Budget 2022, government committed $633M of new funding to help thousands of people maintain and access housing and supports over 3 years**
- ***Belonging in BC* is the first comprehensive Homelessness Strategy for the Province led by the Ministry of Housing in collaboration with several Ministries including the Ministry of Health**

CURRENT SITUATION

- Under a renewed 2022 mandate, the Ministry of Health continues to work with the Ministries of Housing (HOUS), the Attorney General (AG), Mental Health and Addiction (MMHA), Social Development and Poverty Reduction (SDPR), Public Safety and Solicitor General (PSSG), Children and Family Development (MCFD), and Indigenous Relations and Reconciliation (MIRR) as well as with BC Housing, health authorities (HAs) and Indigenous Partners to address the needs of people experiencing homelessness, including those living in encampments.
- In January 2023, the province approved a refreshed Homelessness Strategy, *Belonging in BC* (the Strategy), that sets a framework for government's actions to address homelessness, with a move towards a greater focus on prevention and stability as well as immediate response.
- Budget 2022 allocated $633M over 3 years to fund initiatives under an initial draft of this strategy.
- Strategy actions include implementation of an Integrated Support Framework (ISF) that defines and provides for health and housing supports to help people stabilize in market housing with a rental supplement, ongoing implementation of Complex Care Housing, and planning for expansion of ISF to supportive housing and encampment response teams.
- Also included in the Strategy is the commitment to develop a Provincial Encampment Response Framework to support, reduce and resolve encampments.
- The Strategy announcement is scheduled for April 3, 2023.

Urgent Homelessness Response (UHR) and Encampment Response

- Through UHR funding, health authorities (HAs) have implemented services to support the health needs of people experiencing homelessness, services include:
    - Low barrier team-based primary health care with addiction medicine

  - Harm reduction and overdose prevention services
  - Specialized community MHSU services (such as Intensive Case Management Teams)
  - Traditional healing and cultural wellness supports,
  - Home support services for those transitioning into/residing in supportive housing
- UHR initiatives help alleviate pressure on higher levels of care, such as Complex Care Housing services, emergency departments and acute care services. UHR also provide a foundation for the expansion of ISF across settings.
- The Ministry continues to monitor HAs ongoing implementation of approved initiatives, supporting the transition of UHR initiatives to ISF through 2024/25.
- The Province is also taking a cross-sector coordinated approach to addressing encampments as they arise. A recent focus has been to support unsheltered people in the DTES, ensuring community members impacted by structure removal have access to health care and supports (for additional information, see Fact Sheets Provincial Plan: Supporting Downtown Eastside and Downtown Eastside Homelessness: Mental Health and Substance Use Supports).
- *Provincial Response Plan: Supporting the Downtown Eastside* (the Plan) to be announced March 26, 2023.

Supported Rent Supplement Program (SRSP)

- The SRSP pairs rent supplements with wrap-around supports for people experiencing, or at risk of, homelessness who have mild to moderate health needs and who require additional assistance to maintain or transition to stable housing.
- The Ministry is overseeing the planning, implementation, and evaluation of the SRSP health-related wraparound supports.

Complex Care Housing

- In November 2020, the Minister of Mental Health and Addictions was mandated to lead the development of complex care housing (CCH) to provide an increased level of support for BC's most vulnerable individuals, who have complex mental health and substance use challenges and who are unstably housed or homeless.
- CCH provides enhanced health, mental health and substance use, and social services in housing settings. Services vary across projects, but may include team-based primary care, clinical counselling, psychiatry and mental health treatment, overdose prevention, case management, addictions medicine, Indigenous cultural supports, occupational therapy, and medication management support.
- MMHA is working with implementation leads (the five regional health authorities, Provincial Health Services Authority [PHSA], the Aboriginal Housing Management Association [AHMA], and Ktunaxa First Nation) to implement CCH (for details, see MMHA Estimates Note: Complex Care Housing).

FINANCIAL IMPLICATIONS

- In 2020/21, HLTH provided $2.26 million to VCHA to reimburse costs incurred to support the decampment initiatives related to Oppenheimer Park in Vancouver.
- In 2021/22, HLTH allocated $13.04 million to VCHA to support urgent homelessness and decampment initiatives.
- In 2022/23, HLTH allocated $18.12 million to VCHA to support ongoing urgent homelessness and decampment initiatives and $2.5M for the Supported Rent Supplement Program
- Budget 2023 commits $272 million over 3 years to build on the $633 million over three years to address homelessness announced in Budget 2022. including additional housing and health supports for vulnerable people, and new teams and new housing units to address the needs of people living in encampments.
- Complex Care Housing:
  - Budget 2022 invests $164 million over three years to provide health-focused services within the complex care housing program.
  - Budget 2023 builds on this initial investment, providing an additional $97 million in operating funding to support health-focused services and resources at complex care sites..
  - Budget 2023 also provides $169 million in capital funding (through the Ministry of Housing) over the fiscal plan to deliver more units of complex care housing..

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Homelessness is growing in BC. According to the 2020/21 *Point-in-Time Homelessness Count*, over 8,665 people experience homelessness in BC.[1] According to the 2021 BC *Preventing & Reducing Homelessness Integrated Data Project,* 23,400 people experienced homelessness at one time between January and December 2020, with over half experiencing chronic homelessness (for a period of 6 months or more).[2]
- Homelessness disproportionately impacts Indigenous people; life expectancy is lower for people experiencing homelessness than the general population; and many people experiencing homelessness live with complex health issues including chronic disease, MHSU issues, and physical disability.[3]
- Drafted in 2022, the ISF is a model and system of health, social, cultural, and housing supports for people experiencing or at risk of homelessness across unsheltered and housing settings. It is committed to providing wrap-around supports required to support individuals experiencing homelessness to maintain housing that are accessible, culturally safe, and trauma-informed. The Ministry is responsible for the coordination and integration of physical health and MHSU supports across settings.
- The ISF expands on the work and partnerships initiated in response to COVID-19, such as when healthcare and housing providers came together to deliver health and housing supports for people experiencing homelessness in alignment with the *COVID-19 Joint Provincial Framework for Emergency Response Centres.*

LAST UPDATED

The content of this fact sheet is current as of March 21, 2023 as confirmed by Gerrit van der Leer.

APPROVALS

2023 02 21 – Gerrit van der Leer, Mental Health and Substance Use Branch
2023 03 04– Darryl Sturtevant, Mental Health and Substance Use Division
2023 03 31– Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[1] Homelessness Services Association of BC, Urban Matters and BC Non-profit Housing Association. 2020/21 Report on Homeless Counts in BC. Burnaby, BC: Metro Vancouver. Retrieved from: https://www.bchousing.org/research-centre/housing-data/homeless-counts
[2] Province of BC. (2021). Preventing & Reducing Homelessness Integrated Data Project.
[3] Frankish JC, Hwang SW & Quantz D. 2009. The relationship between homelessness & health: An overview of research in Canada. In: Hulchanski JD; Campsie P; Chau S; Hwang S; Paradis E (eds.) *Finding Home: Policy Options for Addressing Homelessness in Canada.* Chapter 2.1. Toronto: Cities Centre, UofT. Retrieved from: https://www.homelesshub.ca/resource/21-relationship-between-homelessness-health-overview-research-canada

LEGISLATIVE SESSION – ESTIMATES NOTE

Supporting the Downtown Eastside - Provincial Partnership Plan

Topic: Overview of the Supporting the Downtown Eastside: Provincial Partnership Plan Working Document.

Key Messaging and Recommended Response:

- **Residents living in the Downtown Eastside deserve a safe, stable and supportive place to call home.**
- **Over the past several months, the Province has led work with Indigenous, community and government partners to develop and implement a new coordinated response plan to support people in the Downtown Eastside and build on the community's strength and resilience.**
- **On March 26, 2023 the Province released the Supporting the Downtown Eastside: Provincial Partnerhsip Plan Working Document.**
- **It's focused on helping people get off the streets and into homes to resolve encampments, and on strengthening health, social and cultural supports to make the Downtown Eastside a healthier, safer place for everyone.**
- **One of the key measures of the response plan is strengthening access and co-ordination for health, mental-health and addictions services for people in the Downtown Eastside, including through:**
    - **establishing a new multidisciplinary team that will work to identify the needs of people facing homelessness so they can quickly access health and social services and support transitions to indoor spaces as a pathway to appropriate housing options;**
    - **expanded addiction treatment options, such as the new Road to Recovery model of addictions care at St. Paul's Hospital; the first 45 beds are expected to open by fall 2023; and expanded mental-health crisis response teams.**
- **On April 3, 2023, the Province released Belonging in BC: A collaborative plan to prevent and reduce homelessness.**
    - **Belonging in BC is a comprehensive Homelessness Plan for the Province, grounded in prioritizing cultural safety, Indigenous1 and community partnerships, and the inclusion of people with diverse identities and**

needs. Since 2017, Government has taken significant actions to address homelessness through multiple ministries and partners. This Plan brings together ministry, Indigenous and community partners on a shared path with a plan and policy framework to guide coordinated actions.

CURRENT SITUATION

- According to a count conducted in mid-July 2022, there was an estimated 460 people sheltering along East Hastings in Vancouver. Of those, about half were identified as requiring housing. The number of individuals sheltering along East Hastings is fluid and fluctuates from day to day and not all tents seen on the street have individuals residing within them.[1]
- A January 2023 outreach summary showed that 92 people sheltering along Hastings Street are in need of housing, 69 of whom have been sheltering there for at least five months. As of January 24th; 77 structures remained along Hastings St., the lowest amount since reporting began with more than 180 in August 2022.[2]
- Health needs in the Vancouver Downtown Eastside (DTES) are complex, with the client population experiencing mental health & substance use challenges, history of trauma, and Indigenous-specific issues.[3]
- The *Supporting the Downtown Eastside: Provincial Parthership Plan Working Document* outlines the provincial government's approach to restoring community health and safety in the DTES, as well as the prevention of encampments in the DTES from growing and becoming entrenched long-term. Announcement of the Plan is anticipated in March 2023.
- The Plan outlines several goals on how to respond to the needs of the DTES. These goals include:
    - Goal 1: Clear, coordinated, and regular communication with the DTES community,
    - Goal 2: Transition of the DTES back to a safe area by addressing encampment and Single Room Occupancy safety, and providing trauma-informed services,
    - Goal 3: Provision of coordinated transitions and access to integrated health, social, and community services to people sheltering outdoors, and
    - Goal 4: Coordinated access to accessible shelter and housing options.
- In support of the Province's goals of providing coordinated access to health and social services in the DTES, the Plan outlined various actions implicating the health sector such as:
    - The implementation of a coordinated team to engage those sheltering outdoors, facilitate timely connection to health and social services, and support transitions to indoor housing with Vancouver Coastal Health Authority (VCHA) as a partner,
    - Ensuring that health supports move with people to interim and long-term spaces,
    - Expanded treatment and intervention services supporting the DTES such as mental health crisis response teams and a new model of addictions care at St. Paul's Hospital,
    - The provision of health supports and transition planning through existing teams so that supports follow individuals from encampments to indoor spaces and housing.
- There is alignment between the Plan and existing and planned initiatives that can be leveraged to support the DTES response (see Fact Sheet: Downtown Eastside Homelessness: Mental Health and Substance Use Supports).
- A new Supported Rent Supplement Program (SRSP) will provide up to 150 individuals in Vancouver, with rent supplements supported by wraparound health and other mental health/substance use services.

[1] Ministry of Attorney General and Minister Responsible for Housing. (September 06, 2022). East Hasting Encampment Response Issues Note.
[2] Ministry of Housing (February 10, 2023). East Hasting Encampment Response Issues Note.
[3] Vancouver Coastal Health. (December 12, 2022). Proposed Framework for Vancouver Inner City MHSU Supports.

- On February 14, 2023, the City of Vancouver (CoV) approved VCHA's funding proposal for the implementation of an *Urgent Mental Health Services Framework* to support the Downtown Eastside.[4] [5]
- The proposed framework identifies the expansion of the Car 87/88 police partnership service, moderate de-escalation intervention, and a strengthened Indigenous approach across VCHA urgent mental health services as priority for implementation in 2023.
- Subsequent phases of implementation of the framework would involve priority mental health outreach to individuals not currently engaged in health services, expansion of Intensive Case Management teams, and dedicated clinicians to support transitions off MHSU services and connections with community supports where appropriate.

FINANCIAL IMPLICATIONS

- In 2020/21, the Ministry of Health (HLTH) provided $2.26 million to VCHA to reimburse costs incurred to support the decampment initiatives related to Oppenheimer Park in Vancouver.
- In 2021/22, HLTH allocated $13.04 million to VCHA to support urgent homelessness and decampment initiatives.
- In 2022/23, HLTH allocated $18.12 million to VCHA to support ongoing urgent homelessness and decampment initiatives and $2.5M for the Supported Rent Supplement Program.

KEY BACKGROUND

- Key priorities from the 2022 Minister of Health mandate letter: Support the work of the Minister of Housing to better coordinate services to deliver improved outcomes for people living in Vancouver's Downtown Eastside; Support the work of the Minister of Mental Health and Addictions to continue to lead and accelerate B.C.'s response to the illicit drug toxicity crisis across the full continuum of care: prevention, harm reduction, safe supply, treatment, and recovery.
- In Vancouver the 'Housing First' approach is supported through a 2021 Memorandum of Understanding signed by the Attorney General and Minister Responsible for Housing, City of Vancouver and Vancouver Park Board to establish roles and responsibilities in encampment response.
- In 2020/21 and 2021/22 HLTH contingency funding was allocated to VCHA to support decampment activities and new housing sites. VCHA implemented health, and mental health and substance use services to support individuals moving from encampments into indoor spaces in Vancouver.
- On July 25, 2022, Vancouver Fire and Rescue Services issued a Fire Order to remove tents and structures along East Hastings Street due to imminent structure and life safety dangers.
- The City of Vancouver developed a phased Hastings Structure Removal plan that commenced on August 9, 2022, was paused due to a police incident and concern in the community about the approach.
- From July 2022 to January 2023 the fire order for the encampment remained in effect without full enforcement by the City, who have been working with the ministries and other partners to minimize the dangers that prompted the fire order and to assist people sheltering on the streets to move indoors.
- A Provincial Executive Steering Committee (PESC), led by the Ministry of Housing, provides oversight of operational planning and implementation of the encampment response and to ensure the health and safety of unhoused people through access to health and social supports and connections to housing. This committee includes executive representatives from the City of Vancouver, BC Housing, Ministry of Health, Ministry of Social Development and Poverty Reduction, Emergency Management BC, Ministry of Public Safety and Solicitor General, Ministry of Mental Health and Addictions (MMHA) and Vancouver Coastal Health Authority.

[4] https://vancouver.ca/news-calendar/council-receives-proposal-to-expand-collaborative-partnerships-on-mental-health-and-public-safety-in-vancouver.aspx

[5] CoV Meeting Minutes – Council meeting – February 14, 2023. https://council.vancouver.ca/20230214/documents/regu20230214mins.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of April 3, 2023, as confirmed by Gerrit van der Leer. Acting Executive Director, Mental Health and Substance Use Division, Ministry of Health.

APPROVALS

2023 02 21 – Gerrit van der Leer, Mental Health and Substance Use Division
2023 03 04 - Darryl Sturtevant, MHSU
2023 03 21 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Therapies

Topic: Currently, there are a few medications available in Canada to treat patients with COVID-19; the current antivirals recommended for outpatient use are nirmatrelvir/ritonavir (Paxlovid™) and remdesivir (Veklury®). Tixagevimab/cilgavimab (Evusheld™), a long acting monoclonal antibodies, is approved by Health Canada for the prevention and treatment of COVID-19 infection but is not currently recommended for use.

Key Messaging and Recommended Response:

- **In BC, Paxlovid™ is fully covered under PharmaCare for any BC resident with a prescription.**
- **Patients may get a prescription for Paxlovid™ through their primary care provider, or through a centralized intake system by contacting Service BC. They will be screened by an agent for eligibility and if they qualify, be connected with a physician or pharmacists for COVID assessment and treatment (CATe line).**
- **Paxlovid™ may not be a good choice for some people, as there are a number of clinically important drug-to-drug interactions, pre-existing medical conditions and severity of illness that must be taken into consideration when deciding if Paxlovid is the best treatment against COVID-19.**
- **For some people, the side effects of Paxlovid outweigh the treatment benefits, while for others it is a recommended course of treatment.**
- **It's important to note that every situation is unique, and people should contact a primary care provider to discuss whether Paxlovid is right for them.**
- **As of February 28, 2023, 21,338 patients received Paxlovid™ as outpatients in BC. The majority of patients received one treatment course of Paxlovid™.**
- **The BC COVID-19 Therapeutics Committee (CTC) and the COVID-19 Therapeutics Review and Access Working Group (CTRAWG) continue to review emerging evidence and local epidemiological data, and recommend changes to ensure access and appropriate use of Paxlovid™, as applicable.**
- **Interim results from the Therapeutics Initiative's real-world analysis suggests that patients meeting clinically extremely vulnerable definition (CEV1, CEV2 and CEV3) are likely to benefit from taking Paxlovid™. Benefit in the lower-risk patients is less certain and yet to be seen.**

LEGISLATIVE SESSION – ESTIMATES NOTE

- **Remdesivir must be given through a vein and requires visits to a clinic or hospital.**
- **Evusheld is not recommended to use in BC due to lack of efficacy against COVID-19 variants.**

CURRENT SITUATION

- Nirmatrelvir/ritonavir (Paxlovid™) is the first oral antiviral medication which was approved by Health Canada in January 2022. It is recommended for mildly to moderately ill people who are at high risk of developing serious infections.
- Remdesivir is an antiviral with similar indication as nirmatrelvir/ritonavir (Paxlovid™). It is administered intravenously and is recommended for people who are unable to take Paxlovid.
- Tixagevimab/cilgavimab (Evusheld™) are two monoclonal antibodies administered via intramuscular injection for prevention or treatment of COVID-19 infections in individuals expected to have a reduced response to vaccination or who cannot receive a COVID-19 vaccine. However, tixagevimab/cilgevimab (Evusheld™) has reduced activity against various Omicron variants of concern (VoC) and approximately 57% of all VoC in BC is resistant to this drug as of end of December 2022. It has no neutralizing activity against XBB 1.5, a VOC that is currently on the rise. As a result, tixagevimab/cilgevimab (Evusheld™) is not presently recommended as a prevention or treatment.

FINANCIAL IMPLICATIONS

Public Health Agency of Canada procure the COVID-19 therapies on behalf of provinces and the drugs are provided at no cost. However, there are significant costs associated with patient assessments by clinicians and prescribing, distribution of drug to pharmacies and dispensing fees.

KEY BACKGROUND

- COVID-19 Therapeutics Committee (CTC) and COVID-19 Treatment Review & Advisory Working Group (CTRAWG) review clinical evidence for drugs proposed for treatment of COVID-19 and provide recommendation and decision on their use in BC.
- In the pre-Omicron wave, Paxlovid and remdesivir reduced the risk of COVID-19 related hospitalizations and deaths in mild to moderately ill outpatients from about 6% to about 1%.
- Individuals must have tested positive for COVID-19 (by polymerase chain reaction (PCR) or rapid antigen test) and a health-care provder must assess to determine if patients meet the eligibility criteria for treatment.
- Paxlovid is associated with significant drug-drug interactions and contraindications therefore pharmacists are involved in patient medication reviews either prior to prescription being provided by a prescriber or at the time of dispensing.
- In BC, patients may get a prescription for nirmatrelvir/ritonavir (Paxlovid™) through their primary care provider, or through a centralized intake system by contacting Service BC. Since March 1, 2022, all community pharmacies in BC have the ability to order and dispense nirmaltrelvir/ritonavir (Paxlovid™).
- As of April 12, 2022, the CTC and CTRAWG recommend remdesivir be used as the first-line alternative IV treatment if Paxlovid cannot be prescribed replacing sotrovimab, a monoclonal antibody requiring infusion, due to increasing prevalence of variants to which sotrovimab had limited activity.
- Remdesivir was also studied in severely ill COVID-19 patients and was authorized by Health Canada in July 2020 for the treatment of hospitalized patients with pneumonia requiring supplemental oxygen. However, due to lack of clinical benefit in survival, disease progression of length of hospital stay, the CTC does not recommend routine use of remdesivir in severely ill patients.

- As of August 5, 2022, the CTC and CTRAWG recommend that tixagevimab/cilgavimab (Evusheld™) not be used for pre-exposure prophylaxis or treatment, including in severely immunocompromised patients due to insufficient data on effectiveness in patients infected with current COVID-19 variants.
- On January 17, 2023 Health Canada issued updated Health professional risk communication indicating that Evusheld™ may not be effective against certain SARS-CoV-2 Omicron subvariants when used as a prophylaxis or treatment for COVID-19.
- Molnupiravir, also an antiviral is currently under review by Health Canada.

LAST UPDATED

The content of this fact sheet is current as of January 19, 2023 as confirmed by Tijana Fazlagic.

APPROVALS

2023 01 19 - Tijana Fazlagic, Pharmaceutical, Laboratory and Blood Services Division
2023 01 19 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Diabetes Medications and Devices

Topic: The Ministry of Health's review and PharmaCare coverage decision for diabetes medications and continuous (CGM) and flash (FGM) glucose monitors.

Key Messaging and Recommended Response:

- **Effective Thursday, January 5, 2023, drug coverage for two medications has been expanded from limited coverage to regular benefit. The two drugs that became regular benefits are dapagliflozin (Forxiga) and apixaban (generics).**
- **At the same time, two other medications namely, empagliflozin (Jardiance) and semaglutide (Ozempic), that are covered by PharmaCare under specific medical circumstances have had their limited coverage criteria expanded.**
- **This means that more patients are now eligible for coverage of these drugs.**
- **The changes ensure that coverage is aligned with clinical evidence and improve patient access to appropriate medications.**
- **Currently, approximately 2,000 patients in British Columbia benefit from dapagliflozin under limited coverage, and the expansion to a regular benefit is expected to benefit 5,000 more patients in the first year.**
- **Similarly, the expansion of apixaban's limited coverage to a regular benefit is projected to benefit approximately 24,000 more patients, in addition to the curre 45,000 patients who benefit from it.**
- **In 2019, PharmaCare provided limited coverage for empagliflozin (Jardiance) and i 2020 limited coverage for semaglutide (Ozempic) to patients with Type 2 diabetes after they had tried and been unable to control their blood sugar levels by taking t other drugs, metformin and a sulfonylurea drug (e.g., glyburide), or metformin an an insulin.**
- **PharmaCare changed the coverage from third-line to second-line. Patients now or have to try one drug, metformin, before their physician can request coverage of empagliflozin or semaglutide.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- On January 5, 2023, PharmaCare expanded coverage for the sodium-glucose transport protein 2 inhbitors (SGLT2i) and glucagon-like peptide-1 receptor agonist (GLP-1 RA) classes of diabetes drugs. Dapagliflozin (Forxiga) became a Regular Benefit, and empagliflozin (Jardiance) and semaglutide (Ozempic), which were previously third-line Limited Coverage benefits, became second-line Limited Coverage benefits.
- PharmaCare began providing coverage for the Dexcom G6 CGM on June 11, 2021, as a Limited Coverage benefit for patients who meet the Special Authority criteria for the device.
- Evaluation of PharmaCare coverage of and utilization of the Dexcom G6 CGM is currently ongoing.

FINANCIAL IMPLICATIONS

- Coverage of dapaglifozin as a regular benefit is expected to cost $2 million annually before taking into account confidential discounted pricing negotiated with the manufacturer. Generic dapagliflozin is anticipated in 2023, which is expected to reduce the annual spend for this drug.
- CGM and FGM devices are very expensive and may not be affordable for many patients. According to a Health Technology Advisory Committee (HTAC) report on these technologies that was commissioned by the Ministry, the estimated annual per-patient cost of using an FGM is $3,265, and for a CGM is $4,438.[1]
- At list price, it would have cost approximately $100 million over three years to implement coverage for the Dexcom G6 CGM. The Province successfully negotiated a confidential discount.

KEY BACKGROUND

- Since PharmaCare originally began providing coverage for dapagliflozin, empagliflozin, and semaglutide, numerous trials were published regarding safety and efficacy of these drugs and the coverage for these drugs were no longer aligned with current clinical evidence.
- The January 5, 2023 expansion of coverage for dapagliflozin, empagliflozin, and semaglutide ensures that coverage for these drugs are aligned with current clinical evidence and clinical practice.
- BC's HTAC reviewed the efficacy and cost-effectiveness of CGMs and FGMs and has provided a recommendation to the Ministry.
- After the delivery of the HTAC report, the Ministry engaged with the Canadian Agency for Drugs and Technologies in Health (CADTH) to conduct a review of various provincial funding recommendations as well as provide implementation advice for the FGM technology. This review was published in September 2020.
- The Ministry's CGM and FGM working group reviewed the findings from HTAC and CADTH, assessed BC patient and caregiver input, and engaged with clinician stakeholders and patient advocacy group stakeholders to help inform a coverage decision for CGM and FGM devices.
- The Ministry completed a competitive value process with manufacturers of CGM and FGM devices, and the Dexcom CGM was the successful candidate.
- Other products, including the Freestyle Libre and the Medtronic glucose monitoring systems, are not covered by BC PharmaCare.

LAST UPDATED

The content of this fact sheet is current as of January 30, 2023, as confirmed by Tijana Fazlagic.

APPROVALS

2023 01 30 - Tijana Fazlagic, Pharmaceutical, Laboratory and Blood Services Division
2023 02 06 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2023 02 13 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 02 16 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

[1] https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/bc-health-technology-assessment/health-technology-assessments/glucose-monitoring

LEGISLATIVE SESSION – ESTIMATES NOTE

Drug Shortages

Topic: Update on critical drug shortages. There have been a number of impactful and high-profile shortages, involving medications such as pediatric analgesics and nitroglycerine sprays. Mitigation measures and communication strategies are being implemented to manage and minimize the impacts of these shortages.

Key Messaging and Recommended Response:

- **We understand people in BC are anxious about not being able to access important drugs when and where they need them.**
- **Regarding pediatric analgesics, the disruptions have occurred primarily in retail stock, but our stock reserved for Hospitals continues to be stable.**
- **The Ministry continues to work very closely with the manufacturers and distributors of infant and children's acetaminophen and ibuprofen products, Health Canada and other key partners.**
- **Multiple mitigation strategies have been used to address these shortages including Health Canada's actions to secure foreign supply.**
- **As of March 21, 3,156,280 units of children's pain and fever medications were imported into Canada for hospitals, community pharmacies and retail outlets.**
- **The imported supply will supplement the increased domestic production of Canadian supply, which remains at record levels.**
- **The overall supply situation is improving and will likely continue to improve as the peak of the flu season has passed.**

If asked about nitroglycerin sprays:

- **We are aware that there is a limited supply of nitroglycerin sprays across Canada. The shortage of this important treatment of pain from angina was caused by raw material supply issues as well as increased demand.**
- **We can confirm that the shortage is only impacting the retail sector at this time and that health authorities' supply remains stable.**
- **The Ministry is working with Health Canada and partners across the supply chain and health-care system on strategies to conserve existing supply,**

expedite resupplies, extend the expiry date, and access foreign-authorized supply. Health Canada is also evaluating potential alternative drugs.

- **At this time, patients are encouraged to only obtain what they need and to keep expired product in case the expiration date gets extended.**
- **The Ministry is recommending that pharmacists limit the dispensing of these products as much as possible to conserve supply and prevent against stockpiling.**

CURRENT SITUATION

As of March 23, 2023, there are 1,810 actual shortages reported in Canada. Out of these, 25 are currently considered critical and 713 are impacting PharmaCare benefits in BC.

Recent Impactful Shortages

Pediatric Analgesics

- Since earlier this year, supplies of various formats of non-prescription over the counter pediatric/infant and children's acetaminophen and ibuprofen products have been limited in retail and pharmacy locations as well as hospitals across Canada. This shortage is due to unprecedented demand.
- Unlike shortages with other medications, this one was not caused by any major disruptions to the supply chain. Products have been entering the market as usual, but a recent spike in demand has resulted in a shortage since the beginning of summer 2022.
- Multiple mitigation strategies have been implemented by Health Canada with the support of BC to increase supply. These include relaxing the regulated requirements for pharmacists to provided compounded versions of these products, allow for GMP flexibilities where possible to increase domestic production, approve the exceptional importation of foreign-labelled product, issue guidance to the public on how to navigate this shortage.
- As of March 21, 3,156,280 units of children's pain and fever medications were imported into Canada for hospitals, community pharmacies and retail outlets. The overall supply situation is improving and sporadic availabilities has been reported.

Nitroglycerin Sprays

- There is a limited supply of nitroglycerin sprays across Canada. The shortage of this important treatment of pain from angina was caused by raw material supply issues as well as increased demand. At this time, the shortage is only impacting the retail sector. Health authorities' supply remains stable.
- The Ministry is working with Health Canada and partners across the supply chain and healthcare system on strategies to conserve existing supply, expedite resupplies, extend the expiry date, and access foreign-authorized supply. Health Canada is also evaluating potential alternative drugs.
- Communications to the public and a list of products with extended expiry dates is published on the Health Canada website. The Canadian Cardiovascular Society has also developed a Guidance Tool for the health care professional community.
- At this time, the Ministry encourages patients to only obtain what they need and to keep expired product in case the expiration date gets extended. Alternatives such as tablets could be used, were appropriate.
- The Ministry is recommending that pharmacists limit the dispensing of these products as much as possible to conserve supply and prevent against stockpiling

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

Shortages occur when a manufacturer or distributor of a generic or a brand name drug is unable to meet demand. Drug shortages are complex and addressing them is a multi stakeholders responsibility.

- Since 2012, industry associations have administered a voluntary Canadian Drug Shortages reporting website (www.drugshortages.ca) and in 2016 Health Canada introduced regulations which requires drug manufacturers to publicly report drug shortages and discontinuations on the website.

Provincial Work

- The Ministry's role during a drug shortage is to coordinate actions and the flow of information between the different stakeholders including the supply chain.
- In March 2015, the Ministry launched a Drug Shortages web page to provide health professionals and the public with up-to-date information about drugs covered by PharmaCare that are in short supply at BC community pharmacies, including any temporary replacement or alternate products that PharmaCare covers during the shortage. However, the list does not include shortages of drugs PharmaCare does not cover nor hospital drugs. Health Insurance BC manages the web page for the Ministry.
- BC participates in drug shortages task groups/committees with healthcare professionals and Federal, Provincial and Territorial (FPT) governments to identify and develop strategies to manage drug shortages that impact jurisdictions in Canada. The different task groups/committees include:
    - The FPT ADM Drug Shortages Table and the FPT Drug Shortages Task Force. They were endorsed by Deputy Ministers of Health on April 20, 2020, to address COVID-19 drug supply issues including the development of an allocation framework.
    - As of April 2021, BC began a two-year term as the chair of Provincial/Territorial Drug Shortages Task Team (PT DSTT) and as the co-chair of the Multi-Stakeholder Steering Committee on Drug Shortages (MSSC).
        - The MSSC was assembled in 2012 to address drug shortages at the national level. The MSSC is co-chaired by Health Canada and a rotating provincial/territorial co-chair. It includes representatives from industry associations, federal, provincial, and territorial governments, health professional associations and patients. The MSSC meets 2 to 3 times a year and more frequently if needed. Members discuss specific shortages of concern, shortage mitigation and prevention measures and overarching policy issues related to shortages.
        - The PT DSTT is formally established by PT Deputy Ministers of Health (DM). The PT DSTT's mandate is to help identify, prevent, alleviate, and resolve drug shortage situations that have a significant effect on public health and impact on patients. The PT DSTT meets on a bi-weekly basis and more frequently if needed. The PT DSTT chair meets on a weekly basis with the Health Canada Drug Shortages Unit to discuss drug shortages that require active case management.
            - The BC Pharmaceutical Supply Chain Subcommittee (PSCSC) is responsible for developing and maintaining a single BC Health Authority drug formulary, including the policies, structures and procedures that support that formulary. The formulary applies to all BCHA drug use. The PSCSC meets on a biweekly basis.

Federal Level

- During a drug shortage, Health Canada works with drug supply chain stakeholders to determine the details of the drug shortage, coordinate information sharing and identify collaborative mitigation strategies.
- Health Canada has tools and strategies available to assist companies and manufacturers in identifying or accessing alternatives in the event of a drug shortage including:
    - working with manufacturers to review alternate suppliers, changes or expedition in manufacturing processes;
    - working with international counterparts to identify additional sources of supply; and
    - providing the health system with priority access to non-marketed alternatives on an emergency basis via the Special Access Program.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of March 31, 2023, as confirmed by Sue Bouma.

APPROVALS

2023 03 31 - Susan Bouma, Clinical Services and Evaluation Branch
2023 04 11 - Mariana Diacu obo Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Expensive Drugs for Rare Diseases

Topic: Overview of the challenges related to the Expensive Drugs for Rare Diseases (EDRDs), a group of prohibitively expensive drugs associated with limited clinical evidence to support their use, and which benefit a small number of patients; and the national policies and working groups aimed at addressing these challenges.

Key Messaging and Recommended Response:

- **Our government recognizes the importance of ensuring that British Columbians have access to the medications they need to manage rare conditions.**
- **The BC Expensive Drugs for Rare Diseases (EDRD) process is an important step in improving access to high-cost drugs that treat rare conditions for those who need them most.**
- **EDRDs are considered non-benefits, but some drugs and patients may be eligible for coverage on a case-by-case, last-resort basis. Patients will need to discuss their eligibility with their health-care provider.**
- **EDRDs are generally associated with limited clinical information about both the disease and treatment. Because of this, therapies must be carefully reviewed to ensure that the medication is effective for each person being treated.**
- **This means that patients can have confidence that they are receiving treatments that have been thoroughly evaluated and deemed safe and effective.**
- **Manufacturers have set the costs for many EDRDs very high. The costs for these drugs range from $100,000 to more than $3,000,000 per patient per year. By comparison, in 2019/2020, the average PharmaCare beneficiary was reimbursed $1,534 for the year.**
- **Before an EDRD can be considered for exceptional funding on a case-by-case basis, it must undergo the same thorough review as other PharmaCare drugs, but with an additional EDRD patient review process.**
- **The BC-level review ensures that the PharmaCare program remains fair, effective and sustainable. At the end of the review, the Ministry decides which eligible drugs and indications are to be considered for case-by-case funding.**

LEGISLATIVE SESSION – ESTIMATES NOTE

- **Our government will continue to work towards removing barriers and ensuring that British Columbians have access to safe and effective treatments they need.**

CURRENT SITUATION

- There has been significant and sustained growth in EDRDs and, subsequently, patients being assessed through the BC EDRD process. As of January 2023, 404 patients are approved for one of the 25 EDRDs funded by the Ministry of Health on an exceptional, case-by-case basis. In January 2022, there were 251 patients and 24 EDRDs.[1] Currently, there are 14 EDRDs and 16 indications under review, 3 in active negotiations, and a projected patient population of an additional 248 patients this fiscal year compared to the 2021/2022 fiscal year.
    - Since April 2021, six additional EDRD therapies are now considered for exceptional case-by-case funding and 2 additional listings are planned for the 2022/2023 fiscal year. Notable cost-drivers include: increased volume of the number of EDRDs and high patient-volume EDRDs (e.g. Trikafta for cystic fibrosis with 300 patients eligible).
- Advice/Recommentations; Intergovernmental Communications

- The PT EDRD working group, established in 2014, is pausing the work on exploring managed access or funding with evidence development models while the national strategy work is being pursued.
  The Patented Medicine Prices Review Board (PMPRB) delayed the coming into effect of their new proposed guidelines a number of times, from August 2019, to July 1, 2022. An Interim Guidance issued on August 18, 2022 will remain in place until further notice. The new regulations will include modification of the PMPRB comparator countries but exclude other factors such as economic evaluations and market size.

FINANCIAL IMPLICATIONS

- The EDRD expenditures for 2021/22 were at $46.6 million representing significant growth. Expenditures over the past 3 fiscal years were $36.2 million, $32.1 million, and $24.7 million. These costs do not factor in any confidential agreements the Ministry may have signed with manufacturers of EDRDs.[2]
- It is forecasted the EDRD expenditures will reach over $128 million in the 2022/23 fiscal year, with up to 500 British Columbians receiving funding for one of these therapies. The increase is due to approvals of high volume EDRDs in recent years such as Trikafta (in which the coverage criteria have been expanded in 2022 to include the 6-11 age group), and Vyndaqel. The funding of gene therapies with a high initial cost, such as Zolgensma, has also contributed to this increase.
- Based on list prices, the annual treatment cost for EDRD drugs per patient ranges from $195,000 to over $3 million, depending on the drug, weight of the patient, and dosing regimen.

KEY BACKGROUND

- Using a working definition, EDRDs may be defined as drugs used to treat very rare diseases (e.g., incidence rate of <1.65 per 100,000) and with an extremely high annual cost (e.g., >$300,000 per patient). The pharmaceutical manufacturers are now increasingly setting very high prices for more prevalent rare conditions (e.g., 1 in 4000).
- With such considerations of disease rarity, limited evidence, and high per-patient cost, EDRDs raise many ethical, clinical, and financial issues for provincial payers. Because of the poor evidence and cost challenges, these drugs are generally considered non-benefits.

[1] EDRD Ministry Patient Case Database
[2] PHSA EDRD Expenditure Invoices

- The Ministry is experiencing significant growth with the following therapies added in recent years: patisiran (Onpattro), inotersen (Tegsedi), tafamidis (Vyndaqel) and lanadelumab (Takhzyro), Trikafta (elexacaftor/tezacaftor/ivacaftor), Zolgensma (onasmnogene abeparvovec), burosumab (Crysvita) and risdiplam (Evrysdi) taking the total funded EDRDs from 20 to 25.
- The Ministry utilizes a review process for exceptional, case-by-case requests, which includes advice from an arm's-length independent advisory committee and several clinical subcommittees:
    - The Advisory Committee includes expert clinicians who treat rare diseases in pediatrics and adults, a critical care medicine specialist, a health economist, an ethicist, pharmacists, and administrators from the health authority.
    - The Advisory Committee is responsible for evaluating patient-specific funding requests and forwards their recommendations to the Ministry for a funding decision.
    - The Advisory Committee's evaluation may include, but is not limited to: natural disease history, clinical evidence, drug efficacy, alternative treatment options, specifics of individual cases, expected treatment outcome, consequences if the drug is withdrawn/not provided, pharmacoeconomic evidence, budget impact, clinical guidelines, and ethical considerations.
- Since April 2016, the Ministry has partnered with the Provincial Health Services Authority to administer the EDRD process.

LAST UPDATED

The content of this fact sheet is current as of February 2, 2023, as confirmed Tijana Fazlagic.

APPROVALS

2023 02 02 - Tijana Fazlagic, Pharmaceutical, Laboratory and Blood Services Division
2023 02 06 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2023 02 20 - Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Free Prescription Contraception Coverage

Topic: In recognition of the right of BC residents to make and implement informed choices about their sexual and reproductive health, effective April 1, 2023, contraception is free for all BC residents with active MSP coverage.

Key Messaging and Recommended Response:

- **Our government is committed to reducing costs for people and upholding everyone's right to make informed choices about their sexual and reproductive health.**
- **That's why in Budget 2023, we announced that we are making prescription contraception free in BC.**
- **As of April 1, 2023, when a BC resident presents a prescription for an eligible contraceptive at a community pharmacy, they will pay nothing for it. The pharmacist will bill PharmaCare directly.**
- **Also this spring, BC residents will be able to get a prescription for contraceptives directly from their pharmacist.**
- **While universal coverage will be in place as of April 1, 2023, we've taken other actions to lower and eliminate costs associated with prescription medication.**
- **In 2019, we improved access to contraception through major changes to Fair PharmaCare. We invested $95.3 million between 2019 and 2021 to reduce or eliminate deductibles and family maximums for 328,000 low-income families for the first time in 15 years. This gave low-income individuals better access to contraception.**

CURRENT SITUATION

- Effective April 1, 2023, contraception is free for all BC residents with active MSP coverage.
- The Ministry transitioned all current prescription contraceptive products listed on PharmaCare formularies including oral contraceptives, hormonal IUDs, an injection, an implant, and emergency oral contraceptives ('morning after pill') to Plan Z (Assurance), which provides 100 percent coverage to BC residents. At the same time, PharmaCare added copper IUDs as a new formulary benefit under Plan Z.
- To access 100 percent contraceptive coverage, residents will need to obtain their contraceptives from a pharmacy. They can present their prescription at a pharmacy along with their BC Services Card. The pharmacist will bill PharmaCare directly and cannot charge patients for dispensing, assessment or any other action associated with filling the prescription.
- However, if a prescription is for a brand name product, it may not be fully covered. If a patient is taking a brand name contraceptive and PharmaCare covers the generic alternative, then PharmaCare will cover 100 percent of the cost of the generic alternative and the patient will be responsible for the difference.

For 100 percent coverage, the patient can request that the prescriber or pharmacists change their prescription to the generic alternative. Covered generics are as effective and safe as their brand name counterparts.

- The Ministry is working with Options and Foundry nurse-led sexual health clinics to sustain their single-point of service delivery models and provide them with access to free contraceptives. In the meantime, the public can access free contraceptives through a community pharmacy.

FINANCIAL IMPLICATIONS

- In FY 2021/22, PharmaCare paid $3.36 million in drug cost and dispensing fees for contraceptives (including $2.10 million on hormonal contraceptives[1] and $1.22 million on IUDs)[2].
- Government Financial Information

- Budget 2023 dedicates $119 million over three years to make contraceptives free[4].

KEY BACKGROUND

- Offering free prescription contraception to all BC residents supports a range of population health benefits.
- Cost has been identified as the main barrier to accessing prescription contraception in BC.
- Effective April 1, 2023, the Ministry transitioned all current prescription contraceptive products listed on PharmaCare formularies to Plan Z, which provides 100 percent coverage to BC residents.
- In December 2021, the Nexplanon contraceptive implant was added as a regular benefit under PharmaCare.
- Any product available through PharmaCare is reviewed for safety and efficacy; review of an expanded range of contraceptive products may take longer than other implementation activities.
- Planning is underway within the Ministry to strengthen equitable access to contraception-related health services, to align the provision of free prescription contraception with the Minister's Mandate Letter on addressing systemic racism in the health care system, and to align with the principles of anti-racism set out in the Ministry of Health's 2022/23 to 2024/25 and 2023/24 to 2025/26 Service Plans.

LAST UPDATED

The content of this fact sheet is current as of March 27, 2023, as confirmed by John Capelli.

APPROVALS

2023 01 16 - Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 01 18 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2023 01 25 - Bernard Achampong, Population and Public Health Division
2023 03 10 - Maryna Korchagina Population and Public Health Division
2023 03 27 - John Capelli, Pharmaceutical Policy, Legislation and Engagement Branch
2023 04 03- Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

1 This includes hormonal pills and injections.
[2] PharmaNet database. Health Sector Information, Analysis and Reporting. Extracted September 26, 2022.
[3] PharmaNet database. Health Sector Information, Analysis and Reporting. Extracted September 26, 2022.
[4] Budget 2023 takes action on issues that matter most | BC Gov News

LEGISLATIVE SESSION – ESTIMATES NOTE

Out-of-Country Sale of Ozempic

Topic: Ozempic is an injectable prescription drug designed to treat type 2 diabetes mellitus.[1] In BC, from January to February 2023, 15% of Ozempic dispenses were sold to people with addresses in the US, whereas the average of dispenses of other drugs sold to people with addressed in the US is 0.5%[3].

Key Messaging and Recommended Response:

- **To protect the BC supply of the drug Ozempic for BC patients who need it, our government is taking actions to ensure diabetes patients in BC do not experience a shortage of the diabetes drug Ozempic in an environment where surging demand in some jurisdictions is creating shortages.**
- **As announced on March 28, 2023, our government is amending regulations to limit the sale or dispensing of Ozempic to non-Canadian residents to protect the supply of this drug for residents of BC and Canada who need it.**
- **This decision was made on the basis of concerning information learned from a BC PharmaNet data review, indicating an unusually high percentage of prescriptions for Ozempic were emanating from one or more practitioners in Nova Scotia, and a very high percentage of these prescriptions was being dispensed by two internet pharmacies in BC to American residents.**
- **We can confirm that, currently, BC has not experienced any shortages of the drug.**
- **We've learned the Nova Scotia College of Physicians and Surgeons has suspended the licence of a physician identified as having written thousands of prescriptions for Ozempic dispensed in BC.**
- **We appreciate the action being taken by the College and values the cooperation underway with the Nova Scotia Ministry of Health and Wellness.**
- **It is important to ensure prescribing Ozempic is happening within clinical practice requirements to prevent the very serious issue of diverting the BC and Canadian drug supply to the American market.**
- **We also appreciate the actions of the BC College of Pharmacists, which acted swiftly, informing its Nova Scotian colleagues about the very serious concerns**

[1] ozempic-product-monograph.pdf (novonordisk.ca)

surrounding the high number of Ozempic prescriptions emanating from that province.

CURRENT SITUATION

- One of the side effects of Ozempic is weight loss; it has gained popularity as a weight loss medication due to extensive social media coverage. As a result of the social media coverage and heavy marketing, demand for Ozempic has driven shortages of the drug in the US.[2]
- An analysis of dispenses of Ozempic from BC pharmacies to patients located in the US from January to February 2023 shows that 95% were prescribed by one or more prescribers licensed by the College of Physicians and Surgeons of Nova Scotia[3].
- Only 1% of dispenses were prescribed by prescribers licensed by the College of Physicians and Surgeons of BC, with the remaining dispenses prescribed by prescribers from other licensing bodies within Canada.[3]
- On March 18, 2023, Drug Shortages Canada posted a notice of a short-term supply shortage of Ozempic 1 mg.[4] A shortage has not yet been reported in BC.
- On March 28, 2023, the Minister of Health ordered the following immediate actions to prevent an Ozempic shortage in BC:
    - Expedite the amendment of the current regulation to limit the sale or dispense of Ozempic to non-Canadian residents;
    - For the College of Pharmacists of BC (CPBC) to ensure that pharmacies dispensing Ozempic are complying with all clinical dispensing practices; and
    - For the College of Physicians and Surgeons of BC to ensure physicians prescribing Ozempic are complying with the approved indication of the drug and that they meet all clinical practice requirements for prescribing.
- The Minister also requested the Nova Scotia College of Physicians and Surgeons initiate an investigation into the exceptionally high number of out-of-province prescriptions for Ozempic emanating from Nova Scotia practitioners for dispense in BC and take action to address this issue.
- The Minister also requested the federal Minister of Health, the Honourable Jean-Yves Duclos, review the Food and Drug Regulation under the *Food and Drug Act* in collaboration with provincial health ministers to address the concerning number of Ozempic prescriptions emanating from practitioners in one province.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Semaglutide is an injectable prescription drug designed to treat type 2 diabetes mellitus. Under the brand name Ozempic®, semaglutide has been approved by Health Canada for the treatment of type 2 diabetes mellitus in adults.
- Semaglutide under the brand name Wegovy® has been approved by Health Canada for chronic weight management in adult patients.
- PharmaCare currently provides Limited Coverage for Ozempic for the treatment of type 2 diabetes mellitus through Special Authority.
- Under existing provincial and federal legislation, BC pharmacies are legally permitted to fill prescriptions for patients written by US doctors if they are co-signed or re-written by a Canadian practitioner.
- The Ministry has initiated work to amend the Drug Schedules Regulation under the *Pharmacy Operations and Drug Scheduling Act* (PODSA) to prohibit the sale of Ozempic to individuals not physically present in BC.

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[2] Ozempic shortage: Diabetes drug is being used for weight loss | CTV News

[3] PharmaNet, Health Sector Information, Analysis and Reporting Division, April 4, 2023.

[4] Drug Shortage Report for OZEMPIC (drugshortagescanada.ca)

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of March 28, 2023, as confirmed by John Capelli.

APPROVALS

2023 04 05 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 04 12 – Mariana Diacu obo Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2023 04 24 – Updated; Pharmaceutical, Laboratory and Blood Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

PharmaCare's Response to the Opioid Overdose Crisis

Topic: Rising number of unintended overdose deaths due to the poisoned street opioid supply.

Key Messaging and Recommended Response:

- **We know one of the most important ways to save lives during this ongoing public health emergency is to separate people from the toxic illicit drug supply.**
- **That's why in March 2020, at the start of the COVID-19 public health emergency, the Province implemented the first phase of prescribed safe supply in BC and expanded it in July 2021 – the first and only province in Canada to do this.**
- **Budget 2023 builds on this work, providing $184 million over the next three years to support safer substance use to separate people from toxic drugs.**
- **Over the last year, health authorities have been working on establishing and expanding prescribed safer supply programs throughout the province under this policy.**
- **We are doing this work while making sure patient safety is protected, and prescribers have the supports they need.**
- **At the same time, government is working to advance monitoring and evaluation of Prescribed Safer Supply implementation in the Province.**
- **Prescribed safe supply is a critical part of the broader continuum of care and the treatment of addiction as a health issue.**
- **However, we know that safe supply will not solve the toxic drug crisis on its own. That's why the province is transforming mental health and addictions services in BC.**
- **Through historic investments, the government is building a seamless system of care where there wasn't one six years ago, including enhancements across the full spectrum of treatment and recovery, leading the country on decriminalization and investing in life-saving harm reduction measures, like overdose prevention services, supervised consumption sites, and naloxone.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- Unintended overdose deaths due to the poisoned street opioid supply have reached historical levels, with 6.8 people dying daily according to the BC Coroner's latest statistics as of January 31, 2023, mainly because of street opioids being laced with the extremely potent opioid fentanyl and its analogues.[1] This increase began in 2016 and has risen to unprecedented levels over the past couple of years.
- PharmaCare has responded by actively assisting with the identification of and access to pharmaceutical alternatives that support people who use street drugs, to separate from that toxic supply.
- Coverage has been expanded for drugs outlined in the BC Centre on Substance Use (BCCSU) Risk Mitigation in the Context of Dual Health Emergencies (RMG); the opioid option hydromorphone 8mg tablets were added to the Plan G (Psychiatric Medications Plan) formulary to allow for coverage for substance use support.
- Coverage has also been expanded for pharmaceutical alternatives as part of the Prescribed Safer Supply policy (PSS). Risk of harm from the use of street opioids has been added to the fentanyl patch limited coverage criteria, and the patches are now available for coverage under Plan G. Fentanyl buccal (absorbed in the mouth under tongue or via the cheek) tablets were added as Limited Coverage drugs with the same criteria for substance use as the patch, and coverage is now available via all regular plans, including Plan G. Plan G coverage was added to sufentanil injection to ensure that an injectable fentanyl-type option was available for substance use disorder.
- Pharmaceutical Laboratory and Blood Services Division (PLBSD) has also been pivotal in encouraging a Canadian pharmaceutical manufacturer to develop the first domestic supply of injectable diacetylmorphine (DAM). Health Canada approved this product in February 2022 and the Supply Agreement with Provincial Health Services Authority (PHSA) and Pharmascience was signed August 2022. This will significantly expand access to DAM as a treatment for substance use disorder as well as a possible safer supply option. The Product Distribution Centre (PDC) managed by Ministry of Citizen's Services will be the licensed dealer to enable distribution of DAM which meets all the security requirements for the storage of controlled substances. Construction of the PDC vault is slated to be completed in March of 2023.
- PLBSD pharmacists work closely with members of the Overdose Emergency Response Centre and also with the Mental Health and Substance Use branch of the Ministry to proactively respond to emerging needs of those at risk of harm from the street supply.
    - Current active work involves facilitating access to a compounded smokeable opioid option, e.g. fentanyl compounded capsules, as 78% of opioid users prefer smoking to injecting their drug.[2]
- PLBSD pharmacists are actively involved in planning the implementation and monitoring/evaluation of PSS as it evolves and expands scope.
- PLBSD pharmacists are actively monitoring the national supply of opioids used for PSS to ensure supply is available as patient numbers increase and opioid options expand.
- PLBSD pharmacists are working with clinicians, people who use drugs, other government groups, and the regulatory Colleges as needed to lower or remove barriers to access to PSS for patients.

FINANCIAL IMPLICATIONS

- The estimated PharmaCare spend on PSS policies for opioids[3] in 2021/2022 was $6.62m for 7,506 patients.[4]
- PSS estimates are not clearly established as the target population is broad and dosing of drugs within this policy is not yet available. An initial estimate for this policy is $10-15,000/year/patient or $40-90 million a year for the target population reach of 4-6,000 people/year.
- The two-year agreement between Pharmascience and PHSA funded by Ministry of Health costs $15.31M over two years.

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[1] Illicit Drug Toxicity Deaths in B., March 7, 2023 https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/statistical-reports

[2] 2021 BC Harm Reduction Client Survey, April 20, 2022 http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Statistics%20and%20Reports/Overdose/2021%20-%20BC_Overall_HR%20Survey%20%28Apr%2020%29.pdf

[3] Also includes dispenses under RMG for opioids.

[4] PharmaNet, Health Sector Information, Analaysis and Reporting, March 9, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Fentanyl or one of its more potent analogues such as carfentanil was detected in 84% of illicit drug toxicity deaths in 2022.[1] The high potency of fentanyl and analogues makes small amounts lethal if the user is not tolerant to that level due to prolonged use.
- In March 2020, the BCCSU published RMG, which outlined ways to support people who used the street drug supply to mitigate their risks during COVID-19. The guidance included the provision of prescription opioids e.g. hydromorphone 8mg tablets to opioid users so that they did not have seek out a street supply during times of self-isolation/quarantine. This was the beginning of the concept of a safer supply in BC.
- While there was some success with the use of hydromorphone tablets, it was identified that for many people other opioid options needed to be made available to help separate them from the toxic street supply. As a result, PSS was developed with the support of BC Public Health Officer Dr. Bonnie Henry.
- In July 2021, BC's PSS policy went into effect, opening the door to the provision of medical-grade opioid products to people who used street drugs. Fentanyl products were the first to be offered due to the high level of fentanyl in the street supply.
- Research shows that 64% of people who use drugs prefer to smoke or inhale their drug versus inject it.[2] Very few commercial opioid products can be used in this fashion; therefore, compounded options are being sought. Compounded, pre-measured, pharmaceutical-grade fentanyl powder in capsules that can be opened is one innovative option being tried to assist with the need for smokeable products. Cocaine and DAM may also be provided in this fashion.

LAST UPDATED

The content of this fact sheet is current as of, March 3, 2023 as confirmed by Susan Bouma.

APPROVALS

2023 03 03 - Susan Bouma, Pharmaceutical, Laboratory and Blood Services Division
2023 03 07 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
2023 03 10 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 28 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Special Authority

Topic: The PharmaCare Special Authority (SA) program grants full benefit status to drugs, medical supplies or medical devices that otherwise would not be covered or would be only partially covered.

Key Messaging and Recommended Response:

- **Our government is committed to ensuring that patients have access to the medical treatment they need through the PharmaCare Special Authority (SA) program.**
- **The SA program is designed to provide full or partial coverage to a drug or device that otherwise would not be covered or covered only partially. Coverage is provided to patients in specific medical circumstances.**
- **SA requests are made by a prescriber. Coverage is approved for patients who meet the published criteria. In exceptional circumstances, SA coverage may be provided when patients don't meet the criteria or for non-benefit items.**
- **Prescribers can submit SA requests online via eForms or by fax. However, the online eForms option is easier and quicker than faxing, and it generally returns decisions more quickly.**
- **Additionally, SA approval must be in place before a patient pays for a prescription. Coverage is not retroactive.**
- **We understand the challenges posed by the backlog in 2021, and the SA program has taken proactive steps to reduce request wait times.**
- **This includes hiring temporary help, implementing strategies to increase productivity, adding more drugs for auto-adjudication when possible, enrolling practitioners onto the eForms platform, and implementing overtime for current staff.**
- **By the end of 2022, regular-status request wait times have been significantly reduced to six weeks, while urgent requests have consistently been completed within one to two business days.**
- **We'll continue to improve the SA program to ensure British Columbians can get access to the best possible health care.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- The SA program currently receives up to 1,500 requests a day by eForm, fax, and phone submissions. As of January 25, 2023, 79% of submissions are faxed, 17% are eForms and 4% are received by phone/voice mail.
- Target turnaround times for urgent requests is 24 hours (1 business day), and 2 weeks for regular priority requests. The average wait time for the urgent SA phone line is 30 seconds.
- Approval rate is 68%, with 8% returning to the prescriber as Not Approved, 10% requiring more information, and 14% are for patients with coverage already in place for the requested medication. Coverage entry in PharmaNet by SA staff is 95+% accurate.
- For applications submitted by fax, the process can still involve manual paper applications, which has the following challenges:
    - inefficiencies due to errors and missing information (27% of faxed requests are returned due to missing information or errors);
    - technicians and pharmacists spend too much time deciphering and researching information;
    - time-consuming for prescribers; and
    - patients have limited access to their SA information.
- The Special Authority Transformation project (SAT) began in March 2020, to improve service delivery through digitization. This has resulted in:
    - more accurate submissions from eForms with only a 2.02% return rate
    - positive feedback from providers for the ease of use and improved turnaround rates
    - More requests processed (367,444) than received (356,243), in 2022. The difference is reflected in the reduction in the backlog, which was 16,200 at the end of 2022, approximately half of what it was at the end of 2021.

Special Authority Transformation Project (SAT): eForms Platform and SalesForce Case Management System

- In collaboration with the Provincial Health Services Authority (PHSA) Special Authority eForms were introduced on the Provincial eForms Solution platform in 2021; prescribers can submit requests online.
- eForms are far more efficient than fax and phone submissions: some fields are automatically filled (once a prescriber is enrolled); inputs are always legible; there is less room for error in inputs.
- In Phase Two, beginning March 2021, the SalesForce case management system was implemented by the SA team to support adjudication of eForms, fax, and phone submissions.
- All eligible SA medications/devices are available for request through the eForms submission system and can be adjudicated in the SalesForce case management system. Certain drugs (currently 38 medications) are automatically adjudicated, resulting in shorter wait times for patient coverage.
- As of January 20, 2023, PharmaCare has received over 50,000 eForm submissions from prescribers and clinical pharmacists in both the community and health authority settings.
- Also, as of January 20, 2023, PharmaCare has processed over 530,000 SA drug coverage requests through the new SalesForce Case Management system. **Note:** This total includes phone, fax, and eForm submissions.
- As well, SA requests that were processed through SalesForce since May 2021 are now records that patients can access through the Health Gateway portal, rather than contacting their prescriber or pharmacist.
- The SA team is in Phase Three of the SAT project, including new development and improvements to several functionalities based on feedback from health professionals and the internal SA team.

Backlog

- During the backlog of 2021, patients saw up to 11-week wait times for regular-status requests. This was reduced to six weeks by the end of 2022. Urgent requests have been consistently completed within one to two business days. SA managed the backlog by:
    - hiring temporary help;
    - implementing strategies to increase productivity such as: auto-faxing confirmations to prescribers (Auto IT); using SalesForce to make workflow more efficient; and removing unnecessary steps;

- adding more drugs for auto-adjudication when possible;
- enrolling practitioners onto the eForms platform and;
- Implementing overtime for current staff.

FINANCIAL IMPLICATIONS

- Limited Coverage drug (LCD) expenditures for 2021/22 were $657 million of the total PharmaCare drug (ingredients) spend of $981 million.[1]
- 67% of PharmaCare annual drug expenditures for 2021/22[1] were attributed to SA submissions.

KEY BACKGROUND

- To receive coverage, the patient's prescriber must submit a SA request to the Ministry of Health. If the SA request is approved, the drug or device is covered up to the patient's usual PharmaCare plan and coverage limits.
- There are nearly 400 LCDs on the PharmaCare formulary.
- SA coverage may be for a limited time, for example six months or indefinitely, depending on the specific drug and condition being treated.
- Currently, when a coverage decision is reached, SA informs the prescriber by fax. The patient is also updated through the Health Gateway.
- SA coverage is valid from the date approval is entered into a patient's record on PharmaNet (BC's electronic network linking the province's community pharmacies) up until the coverage expiry date. SA approval must be in place before the drug is purchased, as no retroactive coverage is permitted.
- To be eligible for SA funding, the patient must be registered with both the Medical Services Plan and Fair PharmaCare or enrolled in one of the other PharmaCare plans.
- The task of completing a SA request is considered part of a prescriber office visit. Prescribers should not be charging patients for completing SA forms.
- In December 2019, capital funding was granted for the Special Authority Transformation (SAT) project to digitize the end-to-end lifecycle of requests.
- In 2020, PharmaCare launched Phase One for the SAT project through the platform SalesForce to improve service delivery for providers and patients by: providing timely approvals and access to coverage information; improving program processes and efficiencies with automatic adjudications and data entry; and delivering cost-effective drug therapy decisions by validating and auditing clinical coverage criteria.

LAST UPDATED

The content of this fact sheet is current as of January 25, 2023, as confirmed by Susan Bouma, Executive Director.

APPROVALS

2023 02 01 –Susan Bouma, Pharmaceutical, Laboratory, and Blood Services Division
2023 02 06 - Mitch Moneo, Pharmaceutical, Laboratory, and Blood Services Division
2023 02 13 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis and Reporting Division

[1] Health Sector Information, Analysis and Reporting, PharmaNet, February 6, 2023

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Infection Prevention and Control Guidance in Health Care

Topic: Provincial guidance for the prevention and control of COVID 19 in BC health-care settings.

Key Messaging and Recommended Response:

- **In response to the COVID-19 pandemic, our government has implemented a comprehensive strategy to ensure the safety of patients and health-care workers in health-care settings.**
- **On March 20, 2020, the Ministry of Health and Provincial Health Officer issued a Policy Communique including requirements to implement Infection Prevention and Control (IPC) guidance in acute care, long-term care, and assisted living facilities.**
- **Since then, the Policy Communique has been updated twice, on May 19, 2020, and September 1, 2021, to reflect emerging scientific data, evolving epidemiology of the SARS-CoV-2 virus, variants of concern in BC, and expert recommendations.**
- **On April 6, 2023, Dr. Bonnie Henry (PHO) and Minister Dix announced the end of the 2023 respiratory season. The announcement included lifting public health measures and updating Ministry of Health policies for health care settings.**
- **On April 11, 2023, a revised "Mask Use in Health Care Facilities" replaced the Nov. 4, 2021 version of Communique 2020-05 to rescind mandatory universal masking in health care facilities.**
- **Currently, the Ministry maintains over 40 evidence-based provincial IPC guidelines and resources for reducing the spread of COVID-19 in health-care settings.**
- **These guidelines are informed by international, national, and provincial expert recommendations and developed in partnership with health authorities, the Provincial Infection Control Network of BC, the BC Centre for Disease Control, the Office of the PHO, the First Nations Health Authority, and other health system partners.**

LEGISLATIVE SESSION – ESTIMATES NOTE

- **As COVID-19 continues to evolve and changes, the Ministry of Health remains committed to updating and maintaining these guidelines to ensure they remain effective and evidence-based.**

CURRENT SITUATION

- On March 20, 2020, the Ministry of Health and Provincial Health Officer (PHO), issued Policy Communique 2020-01: Infection Prevention and Control for COVID 19 to health authorities. The Policy Communique included requirements to implement Infection Prevention and Control (IPC) guidance in acute care, long-term care (LTC) and assisted living (AL) settings. The Policy Communique was updated on May 19, 2020 and September 1, 2021 with additional content and administrative changes.
- On April 6, 2023, Dr. Bonnie Henry (PHO) and Minister Dix announced the end of the 2023 respiratory season. The announcement included lifting public health measures and updating Ministry of Health policies for health care settings.
- On April 11, 2023, a revised Ministry of Health "Mask Use in Health Care Facilities" policy replaced Communique 2020-05 (Nov. 4, 2021) to rescind mandatory universal masking in health care facilities.
- The Ministry continues to support the provincial pandemic response by updating and maintaining over 40 evidence-based provincial IPC guidelines and resources for reducing the spread of COVID 19 in health-care settings.
- Updates to guidelines are made in accordance with emerging scientific data, evolving epidemiology of the SARS-CoV-2 virus, variants of concern in BC, and expert recommendations.
- The guidance documents are informed by international, national, and provincial expert recommendations, and developed in partnership with health authorities, the Provincial Infection Control Network of BC, the BC Centre for Disease Control, the Office of the PHO, the First Nations Health Authority, and other health system partners.
- BC's approach to reducing COVID 19 transmission is grounded in a comprehensive hierarchy of IPC measures for the prevention and control of communicable disease including the following measures: health measures (e.g., guidance on testing and self-monitoring, contact tracing); environmental (e.g., ventilation, cleaning, disinfection); administrative (e.g., screening, signage, sick leave policies, training); personal (e.g., hand hygiene, immunization); and personal protective equipment (PPE) such as medical masks, eye protection, and gloves.

FINANCIAL IMPLICATIONS

- The Ministry provided an additional $1.6 billion to support the Management of COVID 19: Health Sector Plan for Fall/Winter 2020/21 to sustain the health system restart of health services and to manage the ongoing pandemic. This includes approximately $850 million for several announced initiatives (including increased contact tracing staff, enhanced rural remote transportation framework, single-site staffing, surgical renewal, and increased spending for personal protective equipment).
- On June 30, 2020, the Province announced it would be making approximately $160 million available to help facilities hire full-time equivalent staff to facilitate safe family and social visiting during the COVID 19 pandemic.
- In April 2020, the Province partnered with the BC Care Providers Association to launch EquipCare BC and provided $10 million to enhance IPC and improve quality and safety in LTC/AL settings across the province.
- The acquisition of PPE supplies is managed by the PHSA in consultation with the Ministry and the cost for 2020/21 and 2021/22 was $607 million and $304.1 million respectively.
- Budget 2022 provided approximately $875 million for health related COVID-19 management.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- On April 6, 2023, Dr. Bonnie Henry (PHO) and Minister Dix announced the end of the 2023 respiratory season. The announcement included lifting public health measures and updating Ministry of Health policies for health care settings.
- On April 11, 2023, a revised Ministry of Health "Mask Use in Health Care Facilities" policy replaced Communique 2020-05 (Nov. 4, 2021) to rescind mandatory universal masking in health care facilities by health care workers, non-clinical staff, patients, and visitors to prevent the transmission of COVID-19.
- In September 2020, the Ministry's Management of COVID-19: Health Sector Plan for Fall/Winter 2020/21 outlined a health system plan for the fall/winter period of 2020/21 with actions including:
    - Strengthening standards and guidelines on IPC best practices and outbreak management in Home and Community Care, LTC, AL and acute care sites;
    - Establishing IPC safe and appropriate practice monitoring, reporting, and training across all LTC/AL and acute care sites; and
    - Adding 600 contact tracers and 2,000 staff to protect vulnerable seniors.

LAST UPDATED

The content of this fact sheet is current as of April 17, 2023, as confirmed by Brian Sagar, A/Executive Director, Communicable Disease Prevention and Control Branch

APPROVALS

2023 02 13 – Bernard Achampong, Public Health, Prevention and Planning Branch
2023 02 23 – Dr. Brian Emerson A/Provincial Health Officer, Office of the Provincial Health Officer
2023 03 08 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 17 – Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

COVID-19 Vaccination Program

Topic: The provincial COVID-19 vaccination program.

Key Messaging and Recommended Response:

- **As we enter spring and the third year of the COVID-19 pandemic, it is crucial that we continue to remain vigilant in our efforts to protect ourselves, our loved ones and our communities from COVID-19. This includes staying up to date on our immunizations, which are an essential tool in combating the spread of the virus.**
- **The National Advisory Committee on Immunization (NACI) recently issued guidance on additional booster doses of COVID-19 vaccine. BC will be adopting this guidance.**
- **People at high risk of severe illness including individuals older than 80, all seniors in long-term care homes, Indigenous people older than 70 and people 18 and older who are moderately to severely immunocompromised can get a spring booster.**
- **In addition to high-risk individuals, people 60 and older, or Indigenous people 50 and older, who have not previously contracted COVID-19, can also consider receiving a spring booster dose.**
- **We also continue to encourage everyone six months and older to get immunized with a primary series and, if they're eligible, a booster dose, including anyone 18 and over who has not yet received a bivalent booster dose.**
- **It is important to note that individuals who have not yet been vaccinated are at a higher risk of contracting and spreading infectious diseases and of having more severe illness with COVID-19.**
- **We strongly encourage all individuals to receive their primary series of vaccinations as soon as possible and to consider receiving a bivalent booster if they have not already done so.**
- **Three years into the pandemic, we're all familiar with the power of vaccines. We have one of the highest vaccination rates and lowest fatality rates in North America. Vaccines have also allowed us to get back to our daily lives, gather**

with friends and family and return to in-person work and school, all of which is essential to our health and well-being.

- **We thank everyone in BC for continuing to roll up their sleeves and look out for each other. Together, we will continue to emerge from this pandemic stronger.**

CURRENT SITUATION

Provincial Program for COVID-19 Primary Series and Boosters

- In BC, everyone 6 months of age and older is eligible to receive COVID-19 vaccines for their primary series (i.e., at least 2 doses for most vaccines in BC). A booster dose is currently recommended for everyone 5 years of age and older, at an interval of 6 months after their primary series or previous booster, in order to help maintain protections against severe COVID-19 illness.
- In September 2021, the Province announced a COVID-19 booster program for BC's elderly and those most at-risk of COVID-19. The booster program was expanded in January 2022 to include everyone in BC aged 12 years and older.
- On September 6, 2022, the Province launched a fall booster program for those 5 years and older using bivalent COVID-19 mRNA vaccines.
- Spring 2023 COVID-19 Booster Campaign:
- On March 3, 2023, NACI published new recommendations for an additional COVID-19 vaccine booster dose in the spring of 2023 for individuals at high risk of severe illness due to COVID-19.
- On March 10, 2023, the Province announced a spring 2023 COVID-19 booster campaign based on NACI guidance for people at high risk of severe illness including individuals older than 80, all seniors in long-term care homes, and people 18 and older who are moderately to severely immunocompromised.
- Going over and above the NACI guidance, BC is also recommending a spring booster for Indigenous people older than 70 and advising that high-risk individuals, people 60 and older, or Indigenous people 50 and older who have not previously contracted COVID-19 can also consider receiving a spring booster dose.
- NACI is continuing to monitor the COVID-19 epidemiology and emerging evidence, including the duration of vaccine protection from bivalent booster doses in the coming months to provide recommendations on the timing of subsequent booster doses if warranted.
- The Province typically administers approximately 1,500 COVID-19 vaccinations across BC each day. As of February 5, 2023:
    - 34% of those aged 5 years and older eligible for the fall COVID-19 booster have received the vaccine. In other words, 1,733,828 fall boosters have been administered in BC.
    - 90% ofindividuals aged 12 and older have had 2 doses of the COVID-19 vaccine and 61% have had a booster dose.
    - 42% of people 5 to 11 years of age have had 2 doses of the COVID-19 vaccine and 18% have had a booster dose.
    - 12% of those 6 months to 4 years of age have had 2 doses of the COVID-19 vaccine. A booster dose is currently not recommended for this age group.

FINANCIAL IMPLICATIONS

The purchase cost of COVID-19 vaccines, including the bivalent vaccines, is covered by the Government of Canada.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- COVID-19 is an infectious respiratory disease that is caused by the virus SARS-CoV-2.[1] Some people have a higher risk of infection and of experiencing serious COVID-19 symptoms than others, including older adults and people with underlying health conditions.
- There are several COVID-19 vaccines approved by Health Canada and available for use in BC. Please see Table 1 below for details. In accordance with the National Advisory Committee on Immunization (NACI) recommendations, BC recommends vaccination with the mRNA COVID-19 vaccines to ensure the most effective protection against COVID-19.[2] The original mRNA vaccine is recommended for the primary series and the bivalent mRNA vaccine is recommended for the fall booster dose.
- New this 2022/23 season, individuals can book their seasonal influenza dose at the same appointment where they get their COVID-19 booster using the Get Vaccinated System.[3]
- Children can get the COVID-19 vaccine at the same time as their routine childhood vaccines, including the influenza vaccine. Vaccines approved for use in children are listed in Table 1. Children need a smaller dose of the vaccine to get the same protection from COVID-19 as adults.
- The COVID-19 vaccines are available through pharmacies and health authority public health clinics.

Table 1: COVID-19 Vaccines Authorized for Use in Canada and Available in BC.[4]

VACCINE	AGE GROUP	VACCINE TYPE	COMMENTS
Primary Series			
Pfizer-BioNTech Comirnaty	6 months +	mRNA	It is a 2 dose vaccine. Pfizer is the preferred vaccine for children 5-11 years of age. Dosing for people aged 6 months to 4 years is a 3 dose primary series (lower dose volume). An additional dose is recommended for some people with weakened immune systems. It can be provided as a booster dose to those 5+ if they refuse mRNA bivalent vaccine.
Moderna Spikevax	6 months +	mRNA	It is a 2 dose vaccine. Moderna is the preferred vaccine for children 6 months to 4 years of age. An additional dose is recommended for some people with weakened immune systems.
Novavax Nuvaxoid	12+	Authorized protein sub-unit	It is a 2 dose vaccine. There are limited doses available in BC. It can also be provided as a booster dose for those 18+ if they refuse the mRNA bivalent vaccine.
AstraZeneca Vaxzevria	18+	Viral Vector-Based	Not currently available in BC.
Janssen (Johnson & Johnson)	18+	Viral Vector-Based	Only a single dose is required to be considered fully vaccinated. Individuals who received a single dose of Janssen for the primary series may receive a booster dose at least 8 weeks later.
Medicago Covifenz	18-64 years	Plant-based virus-like particle	Not currently available in BC.
Fall 2022 Booster Dose			
Pfizer-BioNTech Comirnaty **Bivalent**	5+ for use as a booster only	mRNA	This bivalent vaccine targets the original and the Omicron BA.4/BA.5 variants. This vaccine is the only authorized booster for the 5-11 years age group. This vaccine is recommended as a fall booster for people aged 5-11 at least 6 months after their primary series, and for people aged 12+ at least 6 months after their primary series or a previous booster dose.

[6] ImmunizeBC. COVID-19 vaccines. January 12, 2023: https://immunizebc.ca/covid-19.
[7] Government of BC. BC's Response to COVID-19. October 12, 2022: https://www2.gov.bc.ca/gov/content/covid-19/info/response.
[8] The Get Vaccinated System is an online portal developed to improve vaccine reporting, appointment booking, inventory, data entry, and distribution during the COVID-19 pandemic. The Get Vaccinated System is also being used for the delivery of influenza vaccines for the 2022/23 season through pharmacies and public health clinics.
[9] BCCDC. BC Immunization Manual: Part 4: Biological Products. http://www.bccdc.ca/health-professionals/clinical-resources/communicable-disease-control-manual/immunization/biological-products. Accessed February 09, 2023.

VACCINE	AGE GROUP	VACCINE TYPE	COMMENTS
Moderna Spikevax **Bivalent**	18+ for use as a booster only	mRNA	One version of the Moderna bivalent vaccine targets the original and the Omicron BA.1 variant, and another version targets the original and the Omicron BA.4/BA.5 variants. This vaccine is recommended as a fall booster for people aged 5-11 at least 6 months after their primary series, and for people aged 12+ at least 6 months after their primary series or a previous booster dose. This is the preferred fall 2022 booster dose for those who sre moderately to severely immunosuppressed.

LAST UPDATED

The content of this fact sheet is current as of March 14, 2023 as confirmed by Bernard Achampong , Executive Director, Public Health, Prevention and Planning Branch.

APPROVALS

2023 03 14 – Maryna Korchagina, Population and Public Health Division
2023 03 15 – Dr. Brian Emerson,A/Deputy Provincial Health Officer, Office of the Provincial Health Officer
2023 03 15 – Heather Richards obo Martin Wright, Health Sector Information, Analysis and Reporting Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Influenza Seasonal Program[1]

Topic: BC's publicly funded seasonal influenza immunization program.

Key Messaging and Recommended Response:

- **Vaccination remains our best defence, and that's why we made influenza immunizations free for everyone six months and older in BC.**
- **In addition to universal eligibility, 'enhanced' influenza vaccines, which are made to create a stronger immune response to better protect our seniors and elders against influenza, were also offered to all seniors 65+ in BC for the 2022/23 season.**
    - **The enhanced seniors program will also be continuing for the 2023/24 season.**
- **The Province has also made it more convenient for people to get vaccinated against both influenza and COVID-19.**
- **New for the 2022/23 season, people registered with the provincial Get Vaccinated system were automatically sent an invitation to book their influenza immunization online. Walk-ins continued to be available throughout the province for those who preferred to be immunized that way.**
- **The Get Vaccinated system will be used for the 2023/24 influenza season as well.**
- **The best way to protect children from influenza is to get them vaccinated.**
- **This has the added advantage of also protecting other vulnerable family members and friends, as well as easing the pressure on the health-care system.**

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[1] Government of BC. Protect yourself and your loved ones: It's free and easy to get an influenza vaccine | BC Gov News. Retrieved February 7, 2023.
BC Ministry of Health (February, 2023). 74168 - Fact Sheet: Enhanced Influenza Vaccine for Seniors.
Invictus Analytics + Strategy. Weekly Influenza Report, January 31, 2023.
Personal communication with Zaahira Lalani, BCCDC on January 19, 2023
Weekly Influenza Report, January 31, 2023.
Invictus Analytics + Strategy. Weekly Influenza Report, February 5, 2023.
Invictus Analytics + Strategy. Weekly Influenza Report, February 5, 2023.
BC Centre for Disease Control. February 2, 2023. Pathogen characterization.
https://bccdc.shinyapps.io/respiratory_pathogen_characterization/#BC_testing:_counts,_percent_positivity,_historical_trends
Government of Canada. Weekly influenza reports - Canada.ca. Retrieved February 8, 2023.
Email correspondence with Zaahira Lalani, BCCDC. January 19, 2023.
HealthLink BC. "Facts about influenza". https://www.healthlinkbc.ca/healthlinkbc-files/facts-about-influenza. Accessed June 9, 2020.Page 1 of 3

LEGISLATIVE SESSION – ESTIMATES NOTE

- **To ensure an extra push to have more children vaccinated before the holidays, we did a blitz of clinics with lots of walk-in capacity on December 9, 10 and 11, 2022.**
- **More than 77,500 people were vaccinated against influenza from December 5 to December 11, 2022, including 42,582 people who were vaccinated during the weekend's influenza-vaccine walk-in clinic blitz.**
- **This was part of government's efforts to support people and families with children to get vaccinated before the holidays.**
- **This effort resulted in approximately 1.78 million individuals, or 33% of the general population aged six months and older, having received the influenza vaccine in BC for the 2023/24 influenza season as of April 2, 2024. This includes 56.8% of seniors 65+, which is approximately 527,000 individuals, in BC immunized against influenza vaccine.**

CURRENT SITUATION

- The province launched the 2022/23 influenza immunization campaign on October 11, 2022.
- For the 2022/23 season, influenza vaccines are publicly funded for everyone in BC aged 6 months and older.
- In addition to universal eligibility, seniors 65+ in BC are being offered 'enhanced' influenza vaccines for the 2022/23 season. Fluzone High Dose (HD) vaccine is available for seniors 65+ in BC Long Term Care (LTC) and Seniors' Assisted Living (AL) facilities. Fluad vaccine is available for all other seniors 65+.
- For the 2022/23 season, BC purchased 2,223,990 total doses of the influenza vaccine, including 661,150 doses of Fluad vaccine for community-based seniors (65+) and 10,000 doses of Fluzone HD for seniors in Indigenous communities. In addition, the Government of Canada purchased 47,800 doses of Fluzone HD for BC seniors (65+) living in LTC/AL facilities.
- As of February 5, 2023, 1,759,918 influenza vaccine doses have been administered to people in BC by community pharmacists, physicians, nurse practitioners, registered nurses, and public health nurses.
- New for the 2022/23 season, all eligible people in BC can receive an influenza vaccine dose and a COVID 19 booster dose at the same time. As of February 5, 2023, the influenza vaccine has been co-administered with a COVID 19 booster to 242,540 (22.3%) eligible individuals aged 65 years and over.
- As of December 11, 2022, health authorities have administered influenza vaccines to 38,980 (89.3%) residents in long-term care and seniors' assisted living facilities.
- The start of the 2022/23 influenza season coincided with higher-than-expected levels of influenza activity across Canada. Since that time, influenza activity has subsided. Influenza surveillance and testing continues at elevated levels in BC and across Canada.

FINANCIAL IMPLICATIONS

The province invested $22,755,603 to purchase all influenza vaccine doses for the 2022/23 season. Of this amount, $7,353,075 was invested to purchase enhanced influenza vaccines ($6,972,075 for Fluad and $381,000 for Fluzone High Dose for Indigenous seniors).

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Influenza is an acute respiratory illness caused by the Influenza A or B virus. Those at the greatest risk of influenza-related complications include residents of nursing homes, Indigenous peoples, and adults 65 years of age and older.
- In 2021/22, the province administered 1,335,390 influenza vaccines. For the current season (2022/23), the province has already exceeded administration numbers from last year (1,759,918 doses administered as of February 5, 2023). Pharmacies have administered most influenza vaccines (about 70%) over the last 3 years.

Universal Eligibility

- Prior to the pandemic, only populations with higher influenza-related health and transmission risks were eligible for publicly funded influenza vaccines (e.g., seniors, Indigenous people, health care workers).
- Since October 19, 2021, the Province has universal eligibility criteria for publicly funded influenza vaccines during the 2021/22 influenza season. Universal eligibility includes all BC residents aged 6 months and older.

Enhanced Influenza Vaccine Program

- Fluzone HD and Fluad are enhanced influenza vaccines which have been formulated to create a stronger immune response to compensate for the natural weakening of the immune system that occurs with age.
- The enhanced influenza vaccine program for Indigenous elders and seniors in LTC/AL started with the 2020/21 influenza season.
- In November 2021, the Minister of Health approved ongoing, annual funding of the Fluzone HD vaccine program for vulnerable seniors aged 65 years and older living in LTC/AL, and seniors living in Indigenous communities.
- For the 2022/23 season, the enhanced influenza vaccine program was expanded to all other seniors (65+) in community settings.

LAST UPDATED

The content of this fact sheet is current as of March 3,2023, as confirmed by Bernard Achampong, Executive Director, Public Health, Prevention and Planning Branch.

APPROVALS

2023 02 23 – Dr. Brian Emerson A/Deputy Provincial Health Officer, Office of the Provincial Health Officer
2023 03 06 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03 10 – Peter Klotz obo Robert Byers, Finance and Corporate Services Division
2023 04 20 – Maryna Korchagina, Population and Public Health Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Attachment Management System

Topic: The Ministry of Health, in collaboration with Doctors of BC, is developing a primary care "Attachment Management System" (AMS) that will leverage new digital tools and processes to proactively support and manage citizen attachment to longitudinal primary care providers in BC.

Key Messaging and Recommended Response:

- **The Attachment Management System (AMS) will significantly improve patient satisfaction, health outcomes, and reduce health care costs by fostering continuous relationships between patients and primary care providers.**
- **By actively managing patient panels, the AMS enables providers to better address chronic and preventative health care needs, ensuring a higher quality of care for patients.**
- **Launching in July 2023, the AMS will simplify the process of finding a primary care provider by eliminating the need for patients to join multiple waitlists, while also reducing the burden on clinics to maintain their own waitlists.**
- **All family physicians will have to report their patient panels into the AMS, which will provide unprecedented data on BC's primary care system.**
- **That data will help identify room for attachment for patients who have registered in the HCR, which will streamline access to longitudinal primary care and support better reporting and monitoring, allowing for more accurate and efficient primary care planning.**
- **A digital platform approach, complete with automation features, will make it easy for patients and providers to input information into the AMS, minimizing time spent on administrative tasks.**

CURRENT SITUATION

- People who are attached to a regular primary care provider, team, or place of care where there is a continuous relationship over time are more satisfied with their care and consistently show improved health outcomes, decreased mortality, and reduced health care costs, particularly for those with complex health care needs.[1,2,3] Evidence also shows that when providers actively manage their patient panels, they are able to better address their patients' chronic and preventative needs.[4]

[1] Starfield, Barbara. 1992. Primary Care: Concept, Evaluation and Policy.
[2] Berry, Leonard et al. 2008. Patients' Commitment to Their Primary Physician and Why It Matters. Ann Fam Med, 6(1).
[3] FPSC. 2017. Evidence Summary: The Benefits of Relational Continuity in Primary Care.
[4] FPSC panel management, accessed February 14, 2023.

- The focus of the AMS will be to facilitate and improve patient access to longitudinal primary care as well as supporting reporting and monitoring, including enabling more accurate monitoring of who is attached to a primary care provider and where to better inform future primary care planning.[5] Advice/Recommentations

Advice/Recommentations

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FINANCIAL IMPLICATIONS

- To fully implement the new FP compensation model elements and the PCS Refresh as announced in Budget 2023, the Ministry was approved funding for enabling digital IMIT systems, i.e., attachment and clinic registries, Health Link BC (HLBC) digital refresh, mandatory family practice clinic and provider registry database, and electronic medical records (EMR) patient information sharing supported by HLBC virtual care capacity.

Advice/Recommentations; Government Financial Information

KEY BACKGROUND

- Attachment has been a persistent challenge for nearly two decades in BC. Population growth combined with recruitment/retention challenges and an aging population (with more complex needs) have heightened this challenge in recent years.
- The Ministry has relied on the Canadian Community Health Survey and administrative MSP data to estimate and track attachment in the province, but it is recognized that these measures are imprecise, only providing a sense of directionality.

[5] DRAFT Attachment Management System Simplified Project Charter, pg. 9
[6] HCR Policy Decisions Presentation, February 2023, slide 9.

- In October 2022, the Government announced a new longitudinal family physician payment model. The new model is designed to attract and retain family doctors with full-service family practices. The Government further committed to developing a provincial rostering system to ensure patient care continuity.[7]
- On February 1, 2023, the Government launched the new payment model and stated that it aimed to have a digital rostering system in place by July 2023, to determine where capacity exists throughout the province to attach patients to clinics and providers.[8]
- HealthLink BC (HLBC) developed and launched a proof-of-concept Health Connect Registry (HCR), now the attachment service through the AMS, in 2019 to facilitate attachment to longitudinal care providers. As of December 2022, almost 30,000 HCR registrants were successfully attached to a family doctor or nurse practitioner in participating communities.[9]
- As part of the application process to access clinic stabilization in the Fall of 2022, medical directors were required to submit data on their clinics and providers/staff through a survey administered by Doctors of BC. The survey results are being used as the basis for developing a comprehensive provider-clinic registry.

LAST UPDATED

The content of this fact sheet is current as of March 7, 2023, as confirmed by Kelly McQuillen and Jennifer Gough.

APPROVALS

2023 03 16 - Ted Patterson, Primary Care Division
2023 04 06 - Kerri Harrison obo Rob Byers, Finance and Corporate Services Division

[7] BC Gov News, BC healthcare system strengthened by new payment model for doctors, October 31, 2022
[8] BC Gov News, New payment model for physicians means better care for patients, February 1, 2023
[9] DRAFT HCR Attachment Policy DBN December 2022, pg. 1, data extracted by HLBC team December 2022.

LEGISLATIVE SESSION – ESTIMATES NOTE

Community Health Centres

Topic: Community Health Centres (CHCs) are typically multi-sectoral health organizations providing a community population with primary health care in a geographically defined area, although a CHC may target its services to a community of specialized need residing across multiple geographical areas. CHCs are typically team-based, community-governed, not-for-profit or co-operative organizations that prioritize attachment of under-reached populations and are a valuable resource in helping to address social determinants of health through linkages to other community agencies.

Key Messaging and Recommended Response:

- **As part of our 2018 Primary Care Strategy, Community Health Centres (CHCs) are critical to creating a modern primary care system.**
- **These centres are designed to bring together a range of healthcare professionals, including physicians, nurse practitioners, and others, to work collaboratively and provide a patient-centered approach to care.**
- **They are a favored form of practice among many new family physicians and are critical to providing improved wrap-around care to BC's growing population of complex patients.**
- **By doing so, they ensure that patients have access to the right care, in the right place, and at the right time. CHCs provide care based on the needs of the community they serve, such as:**
    - **prevention and health promotion;**
    - **helping patients to manage chronic conditions;**
    - **providing mental health and addiction support; and**
    - **providing culturally safe care to Indigenous peoples.**
- **As of January 2023, the Ministry has provided funding through its Primary Care Strategy for six new CHCs: RISE CHC (Vancouver Coastal); Roots CHC (Fraser); Island Sexual Health CHC, Westshore CHC and Luther Court CHC (Vancouver Island); and Umbrella Multicultural Health Cooperative (Fraser); 69.2 full-time equivalents (FTEs) out of a total 93.6 budgeted FTEs have been hired as of January 10, 2022.**

- **Since 2018, the Ministry has also provided significant grant funding ($9.04 million) to the BC Association of Community Health Centres (BCACHC) to support CHCs in the province.**
- **Participating members are highly accountable to their patients and communities and provide a range of programming and access for primary health care, health promotion, and the social determinants of health delivered by interdisciplinary care teams.**
- **We look forward to supporting the introduction of more CHCs offering tailored care to the communities they serve in Primary Care Networks across the province.**

CURRENT SITUATION

- As of January 2023, the Ministry of Health has provided funding through its primary care strategy for six new CHCs: RISE CHC (Vancouver Coastal); Roots CHC (Fraser); Island Sexual Health CHC, Westshore CHC and Luther Court CHC (Vancouver Island); and Umbrella Multicultural Health Cooperative (Fraser).
- In these six CHCs, 69.2 full-time equivalents (FTEs) have been hired, out of a total 93.6 FTEs that have been approved for hire.[1]
- The Ministry is actively supporting the planning of new or enhancing of CHCs across the province including Lake Country, STEPS, and Rutland (Interior); Elizabeth Fry (Fraser); Sooke and Campbell River (Vancouver Island); and Bowen Island (Vancouver Coastal).
- The Ministry has worked collaboratively to strengthen CHC development and to determine interest to leverage two new CHCs (Central Interior Native Health Society in Prince George, and the Sooke Region Communities Health Network) for potential hybrid CHC/Urgent and Primary Care Centre (UPCC) models, as the province looks to implement more UPCCs over the coming two years.
- The Ministry has provided significant grant funding to the BC Association of Community Health Centres (BCACHC) to support CHCs in the province (see below).
- As of February 2023, there are 42 registered BCACHC members, which includes both CHCs and "emerging" CHCs, which are communities who have a not-for-profit as a BCACHC member while they work to become a CHC. These members are highly accountable to their patients and communities and provide a range of programming and access for primary health care, health promotion, and the social determinants of health delivered by interdisciplinary care teams.[2]
- There are also currently over 100 health authority owned and operated CHCs across BC providing a range of health and non-clinical services, often including primary care, but not necessarily. However, these CHCs typically do not have the same community governance model as independent CHCs.[3]

FINANCIAL IMPLICATIONS

- As of January 2023, the estimated annual operating costs for the six CHCs currently in operation are $17.2M.
- Across all CHC's, 1 has required capital funding, consisting of $0.9M from the Ministry.
- *Budget 2023* includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides

[1] Results Management Office, Primary Care Division. Period Workforce Report to January 5, 2023 (P10); submitted by Regional Health Authorities.
[2] https://bcachc.org/our-members/. Accessed February 22, 2023. Adjusted total of active members verified through direct communication with BCACHC Executive Director February 22, 2023.
[3] Compiled from regional health authority online listings of community health centres. Reviewed February 22, 2023.

a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		Government Financial Information
Budget 2023*	$399.1			
Grand Total	**$679.4**			**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

- As part of the NDP 2017 election campaign, 4 commitments were made by the NDP to the BCACHC: Allocating up to $6M to support existing CHCs in 2017/18; establishing a partnership table with BCACHC and partners; commencing with annualized funding for existing CHCs by 2018/19; and seek to expand the CHC model by 2020.[4]
- In 2019, following a series of community consultations, the Ministry completed an evidence- and partner-informed draft CHC policy directive outlining service model expectations for Ministry funded CHCs in BC.
- CHCs in BC are often categorized as health authority owned and operated or community-governed and operated. Most community-governed and operated CHCs do not receive Ministry core operational funding, though many receive sustainment or emergency funding from the Ministry via BCACHC. Other service arrangements may be supported by health authorities or CHCs may be funded through Fee-for-Service. CHCs may also receive partial or ongoing funding from other provincial ministries (e.g., Ministry of Children and Family Development). Many existing CHCs were built and paid for by local community members who still finance major portions of the health and social services delivered.
- Since March 2018, the Ministry has provided BCACHC with four one-time operations and CHC stabilization grants totaling $9.04M ($2.13M in 2017/18; $1M in 2019/20; $2.13M in 2020/21; $3.78M in 2021/22) to promote the vision of health and well-being through the CHC model, and to help address urgent clinical service gaps experienced by many CHCs across the province.
- Team-based care in CHCs will provide varying degrees of primary care services and enable patient access to an inter-disciplinary team of health care professionals that may include, for example: Family Physicians, Nurse Practitioners, Social Workers, Community Health Workers, Traditional Wellness Providers, Elders, and Mental Health and Substance Use Clinicians.

LAST UPDATED

The content of this fact sheet is current as of February 27, 2023 as confirmed by Shana Hall obo Shana Ooms.

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division

[4] BC New Democratic Party, Letter to Grey Showler, President-BC Association of Community Health Centres. April 2017.

LEGISLATIVE SESSION - ESTIMATES NOTE

FP and NP Primary Care Payment Models

Topic: In support of the Primary Care Strategy, the Ministry of Health introduced a number of new payment models for family physicians (FPs) with the goal of increasing patient attachment, access, and quality of care. New To Practice (NTP) and Nurse Practitioners (NPs) were introduced in 2018 to support recruitment into these positions. The Group Contract for Full-Service Family Physicians was introduced in 2020 along with a refreshed NTP contract to align with the Group Contract. In 2022, NTP incentives were introduced to recruit recent physicians who recently completed their family medicine residency into longitudinal family practice. In February 2023, the Ministry launched the Longitudinal Family Physician (LFP) payment model, developed in response to early FP retirements due to COVID-19 practice impacts, the increasing concern about the cost of operating a clinic, and compensation differentials between longitudinal family practice and other practice options for FPs.

Key Messaging and Recommended Response:

- **Over the past years, many family physicians have also told us that fee-for-service (FFS) is no longer working for primary care, either for them or for their patients.**
- **That is why we worked with the Doctors of BC and the BC Family Doctors to create the new Longitudinal Family Practice (LFP) payment model.**
- **The new model builds on the learnings of the recent FP contract models and FFS, and includes payments for:**
    - **time spent on direct care;**
    - **indirect care and clinical administration;**
    - **number of patient visits; and,**
    - **the size and complexity of a family physician's patient panel.**
- **The model compensates family physicians for time spent managing and coordinating their patient care, which we know may involve much more than the initial visit with a patient.**
- **A full time family physician practicing under the new LFP model is expected to earn approximately $425,000 in 2023/24, up from $385,000 in 2022 due to negotiated increases in the 2022 Physician Master Agreement. Time makes up the most significant portion of these earnings, followed by patient interactions, and the panel payment.**
- **The LFP payment model is seeing remarkable interest, with 2,743 physicians enrolled as of April 12, 2023.**
    - **Over 57% of whom were longitudinal family docs last year.**

- **Moreover, 240 physicians who were not in the system last year have enrolled.**

- **We also introduced the New to Practice (NTP) Incentives Program in 2022, to provide incentives such as signing bonus, medical education debt relief grant, and increased payments for overhead for physicians who have recently completed their family medicine residency program. The program has been extended into 2023/24.**
- **Between June 2022 and February 25, 2023, 120 new contracts have been signed (along with 201 additional Expressions of Interest) as part of the NTP program.**
- **We expect the percentage of family physicians participating in full-service family practice to rise significantly based on the reception we have received from doctors after introducing the new LFP model and NTP incentives.**
- **We are heartened by the remarkable progress we have made so far and will continue working with the Doctors of BC to ensure doctors have the compensation they need to do what they do best — care for patients.**

CURRENT SITUATION

- In August 2022, the Ministry launched the NTP Incentives Program targeted to new-to-practice FPs who have recently completed their family medicine residency program and wish to establish a full-service longitudinal practice. The incentives include:
  - An increased Year 1 NTP contract rate of $295,457 ($275,057 plus $20,400 for Quality Improvement per year, per FTE)
  - Clinic overhead contributions of $75,000 per year, per FTE, also included in the NTP contract
  - One-time signing bonus of $25,000 per FTE
  - One-time medical education debt relief grant of up to $50,000 per FTE in the first year of practice with potential for debt relief grants of up to $20,000 per FTE per year for years 2-5.
- Between June 2022 and February 2023, 120 FPs have signed onto the revised NTP Contract.[1]
- In February 2023, the Ministry launched the new Longitudinal Family Practice payment model. The new model provides an alternative to fee-for-service. The LFP payment model has three payment components in response to physician feedback and to support the Ministry's health system objectives. This model better supports team-based care, and the way physicians want to practice providing patient-centric longitudinal care. The three payment streams compensate for:
  - Time spent on:
    - Direct patient care services
    - Indirect patient care services
    - Clinical administration
  - The number of patient visits
  - The physician's patient panel size and complexity
- The model is built around a full-time longitudinal FP:
  - Providing 1680 hours of service annually
  - Panel size of 1250 patients of average complexity

[1] New-to-Practice Incentives Program Update Report – February 11, 2023

  - Providing 5000 patient encounters annually
- A full-time FP is expected to earn $425,000 [TBC] per year, up from $385,000 in 2022 due to negotiated increases in the Physician Master Agreement. Time makes up the most significant portion of these earnings, followed by visits, and the panel payment.
- The model requires a minimum commitment of 1 day per week and 250 patients, and there is no maximum FTE, allowing individual choice to provide increased hours of service, number of consults, number of patients attached.
- As of April 15, 2023, 2,743 FPs have registered to bill under the new Payment Model. This equates to more than 1/3 of FPs identifying as longitudinal primary care providers – a remarkable and unprecedented accomplishment in a very short period of time.

LFP Registrations by Health Authority

	1 Interior	2 Fraser	3 Vancouver Coastal	4 Vancouver Island	5 Northern	Province Wide
Number of Registrants	534	839	778	470	122	2,743
Proportion by Health Authority	19%	31%	28%	17%	4%	100%

- The Ministry is currently in discussions with the Nurses and NPs of BC regarding updating the compensation options available to support NPs in primary care, which are currently limited to the service contracts or employed positions.

FINANCIAL IMPLICATIONS

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Government Financial Information		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

NTP and Group Service Contracts

- In October 2020, the Ministry introduced a new Group Contract for Practicing Full-Service Family Physicians (Group Contract for FPs), developed in consultation with the Doctors of BC. As part of the consultation process, the FP Contract originally introduced in 2018 for FPs without an existing panel (New to Practice contract) was revised to align with the new Group Contract for FPs.
- The NTP and Group Contracts require practitioners to agree to become part of a PCN in their community and to adopt the attributes of the Patient Medical Home where applicable.[2] Practitioners also commit to act as the most responsible primary care provider for a patient panel that is balanced (e.g., age, complexity). For NTP, FPs and NPs are expected to join an existing group practice or establish a group practice.
- NTP and NP Contracts panel size targets increase during the term as follows, for 1.0 FTE:
  - FPs: 800 patients in year 1 of the contract term and 1,250 patients in year 2.

[2] Patient Medical Home in BC http://www.gpscbc.ca/sites/default/files/PMH%20graphic%20%2020160920.pdf

  - NPs: 500 patients in year 1, 800 patients in year 2, and 1,000 patients in year 3.
- 1.0 FTE of services is defined as:
  - 1,680 to 2,100 hours per year for FP
  - a minimum of 1,680 hours per year for NPs.

  To ensure continuity of care over the year, each FTE FP and NP may work a maximum of 90 hours over two weeks.
- For NPs the annual contract payment rates and separate overhead payment are:
  - $150,000, $155,000, and $160,000 for years 1 to 3 for 1.0 FTE; and overhead allocations of $75,000 for rural and $85,000 urban/metro communities.

Alternative Payments Program (APP)

- In addition to NTP and Group Contracts and the LFP Payment Model, the Alternative Payment Program (APP) is also available for health authorities and other agencies to engage physicians on a service contract, salary, or sessional basis in situations where the fee-for-service payment modality would be ineffective in attracting and maintaining adequate physician services. The Primary Care Strategy has leveraged this form of remuneration particularly in rural and remote communities where family physicians provide “generalist” care, meaning they work in office, but also in hospital and other settings in the community.

LAST UPDATED

The content of this fact sheet is current as of April 14, 2023, as confirmed by Shana Hall obo Shana Ooms, Jennifer Gough and Kelly McQuillen.

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division
2023 04 17 - Kerri Harrison obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Health Connect Registry

Topic: The Health Connect Registry (HCR) is a provincial, online solution where patients can register themselves, their family, or a person in their care for attachment to a family doctor or nurse practitioner in their Primary Care Network (PCN). The HCR provides PCN and Division of Family Practice attachment coordinators across the province the interface required to collect additional patient details and facilitate matching patients to available providers in their community. The HCR is being integrated into a new digitally enabled provincial attachment management (rostering) system being developed in the province for July 2023.

Key Messaging and Recommended Response:

- **Since the introduction of our Primary Care Strategy in 2018, we have been soft launching the Health Connect Registry (HCR) in Primary Care Networks across the Province in anticipation of full provincial access.**
- **The HCR allows patients to sign up to connect themselves with a primary care provider in their primary care network.**
- **Patients are attached in the system in chronological order, with some patients with complex conditions being set as a priority.**
- **Primary care in BC has traditionally been administered through physician-owned practices that are provided payment for publicly insured services through MSP. This has made collecting patient data on attachment difficult from a Provincial perspective.**
- **The HCR is a critical part of the province's initiatives to create a system to measure attachment and identify capacity in the system for new patient attachment.**
- **The HCR is one more way we are building a primary care system that makes care more accessible to all British Columbians.**

CURRENT SITUATION

- As of January 5, 2023 (Period 10), there are 105,909 registrants on the HCR who are waiting for attachment; since launching, there are 18,938 registrants who have been successfully attached to a primary care provider through the HCR. An additional 9,471 registrants were attached in Kamloops using the original waitlist prototype prior to HCR. In total, HealthLinkBC (HLBC) has supported communities with 28,409 attachments since 2016.[1]
- There are 21 PCN communities now active on the HCR: Campbell River, Central Interior Rural, Chilliwack, Comox Valley, Cowichan, East Kootenay, Fraser Northwest, Kootenay Boundary, Nanaimo, Northern Interior

[1] HealthLinkBC Health Connect Registry Data, January 31, 2023.

Rural (Quesnel), North Peace, Oceanside, Prince George, Richmond, Ridge Meadows, Saanich Peninsula, South Okanagan Similkameen, Surrey - North Delta, Thompson Region, Victoria, and Western Communities.

- HLBC is working with the following eight PCN communities to launch the HCR: Central Okanagan. Gabriola, Mission, Pacific Northwest, Sunshine Coast, Vancouver, White Rock - South Surrey, and the various PCN communities included in the Rural and Remote Division of Family Practice.
- The Ministry of Health (the Ministry) deployed a "soft launch" approach to the HCR proof of concept, meaning that HLBC implemented the HCR one PCN at a time, with no public advertisement, social media, or announcements. The scalability and user experience of the HCR application required validation by early adopter PCNs to inform a broader provincial rollout. Furthermore, the soft launch provided PCNs the necessary time to establish, implement an attachment coordination function, develop local attachment processes, and have primary care providers available, or be actively recruiting them.

Advice/Recommentations

- These readiness measures will better prepare the Ministry (and PCNs) to launch the HCR provincially for July 2023, and to advertise and promote HCR availability across BC as part of a broader, digitally enables provincial attachment management system.

FINANCIAL IMPLICATIONS

- In 2018/19, $288,000 in capital funding went into the initial development of the HCR proof of concept.
- In 2019/20, 2020/21, and 2021/22, maintenance of the HCR was funded through the Primary Care Division, HealthLinkBC annual operational web maintenance budget.

Advice/Recommentations; Cabinet Confidences

- Family Practice Services Committee (FPSC) provides $25,000 annually to each PCN to fund dedicated attachment personnel. PCNs must have a primary care coordinator in place (employee who is responsible for attaching patients on the HCR to a provider) before the HCR can be launched in the community.

KEY BACKGROUND

- The HCR became operational in June 2019, in conjunction with the implementation of PCNs, based on a prototype launched in Kamloops in 2016. The onboarding of PCNs to the HCR began in earnest in 2021, as for most of 2020, HLBC 8-1-1 and PCN services were largely dedicated to the COVID-19 pandemic response.
- Several PCNs have community attachment waitlists in place at the PCN, Division of Family Practice, or clinic level. When the HCR launches in a community, current local attachment waitlists are merged into the HCR, providing the community with a single, centralized waitlist of patients to attach from. It also provides the Ministry with comprehensive data from a given community on patients' interest in attachment.
- The HCR provides each community's attachment coordinator with a secure administrative interface to review, append, and collate patient information, in order to support local attachment. HLBC also provides each PCN with a webpage on healthlinkbc.ca to share information with their community on current attachment activities, and on access to care in community in the interim of a primary care provider.
- Residents of participating communities are informed of the HCR at a point of care (clinics, pharmacies, hospitals, etc.). QR (quick response barcodes) codes to the HCR are made available on posters and business cards, and PCNs engage directly with providers in the community. Online and in-clinic references to previous community waitlists are replaced with information about HCR online registration.
- The HLBC HCR delivery model aims for 80% registration online and 20% registration by phone (8-1-1). Ensuring all British Columbians can register their interest in attachment to a primary care provider regardless of digital literacy is an important success factor for the HCR. 8-1-1 navigators can register patients who may not have online access, or who may require translation or additional support.

- HLBC is a trusted source of health information and advice for people in communities throughout the province and is well positioned to support patients with registration for attachment. During the registration process, HLBC can also provide health information, when and where to seek care in a community, and immediate virtual care access through HLBC's clinic team.

LAST UPDATED

The content of this fact sheet is current as of February 27, 2023, as confirmed by Sandra Sundhu.

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division

LEGISLATIVE SESSION - ESTIMATES NOTE

Indigenous Primary Care Initiatives

Topic: Enhancing access to culturally safe primary care for Indigenous people is a key focus of primary care strategy in BC. Primary Care Networks (PCNs) are expected to actively engage First Nations and Métis community representatives, ensuring their needs are incorporated into services for the community.

Key Messaging and Recommended Response:

- **The Ministry prioritizes Indigenous health and wellbeing and seeks to deliver health care services aligned with the UN Declaration on Indigenous Rights, Truth and Reconciliation Commission, and In Plain Sight (IPS) report.**
- **IPS recommendations are implemented through First Nations health plans, mental health support, Indigenous recruitment, anti-racism initiatives, and cultural humility training.**
- **The 2020 Rural, Remote, First Nations, and Indigenous COVID-19 Response Framework offers a lasting solution to address the health needs of Indigenous and rural communities.**
- **As at January 2023, the Ministry has committed $6.33M in annual funding for 60.2 full-time equivalent (FTE) Traditional wellness supports in Indigenous communities via Primary Care Networks, Community Health Centres, and First Nations Primary Care Clinics.**
- **Currently, 35.5 FTEs are hired to provide culturally safe, team-based primary care across the province.**
- **We are committed to building a health care system that is responsive to the needs of Indigenous peoples and will continue building programs that deliver culturally safe care.**

CURRENT SITUATION

- The Ministry is committed to enhancing the health and wellbeing of Indigenous peoples, as identified through the United Nations Declaration on the Rights of Indigenous Peoples, the Truth and Reconciliation Commission, and the *In Plain Sight (IPS): Addressing Indigenous Specific Racism in BC Health Care* Report. [1]
- The IPS recommendations are being actioned through First Nations health plans and agreements, as well as mental health and wellness and substance use, Indigenous recruitment, hard-wiring anti-racism, cultural humility, and trauma-informed training.
- The 2020 Rural, Remote, First Nations and Indigenous COVID-19 Response Framework includes: overarching guiding principles; definition/description of rural, remote and First Nations and Indigenous geography; and

[1] https://engage.gov.bc.ca/app/uploads/sites/613/2021/02/In-Plain-Sight-Data-Report_Dec2020.pdf1_.pdf

planning for a patient choice enabled rural and remote system. This framework will provide a permanent and needed operational platform framework to better meet the urgent and emergent health needs of First Nations and Indigenous communities, and rural or remote communities.

- As of January 2023, The Ministry has committed $6.33M in annualized funding for 60.2 full-time equivalent (FTE) Traditional wellness supports for Indigenous communities through PCNs, Community Health Centres, and FNPCCs.[2] 35.5 FTEs are currently hired and supporting culturally safe team-based primary care delivery across the province.[3]

PCNs
Advice/Recommentations; Intergovernmental Communications

FNPCCs

- The FNPCCs are health and wellness centres where traditional and cultural practitioners work alongside a team of primary care professionals to support the holistic health of Indigenous people. The centres are intended to significantly transform and improve access to primary health care for Indigenous peoples in the province by addressing the social determinants of health, health equity, access, and attachment to a team of care providers supporting both western and Indigenous health and wellness practices.
- Two FNPCCs are in operation (Lu'ma Medical Centre and Williams Lake First Nations Wellness Centre),
Advice/Recommentations; Intergovernmental Communications
Advice/Recommentations; Intergovernmental Communications

- As of January 2023, 21.7 FTE of the total approved 32.3 FTE (67%) for the two FNPCCs in implementation (Lu'ma Medical Centre and Williams Lake First Nations Wellness Centre) have been recruited.[3]
Advice/Recommentations; Intergovernmental Communications

Provincial Partnerships

- The Joint Project/ Priorities Board (JPB) is an FNHA and Ministry partnership supporting 27 primary and community care projects. Examples of approved projects include implementing multi disciplinary teams with physician/nurse practitioner leads, mobile mental health and crisis response units for children, youth, and adults, and a wrap-around chronic disease management and prevention team.
- IPS recommendations are actioned in part through the jointly co-chaired Ministry and FNHA Indigenous Cultural Safety and Humility (ICSH) in Primary and Community Care Provincial Working Group. Established in 2021, the group includes Ministry and FNHA representatives with Métis Nation BC, health authorities, Doctors of BC, Colleges and health system stakeholders.

Advice/Recommentations

Advice/Recommentations

Advice/Recommentations

[2] Data retrieved from Ministry of Health, Results Management Office, Primary Care Division, Primary Care Workforce Report – FY2022/23 (Period 10). Of his total, 9.0 FTE were funded by the First Nations Health Authority at FNPCCs.

[3] Data retrieved from Primary Care Network Funding Letters and Change Requests as at January 2023 for the following PCNs: Chilliwack & Fraser Health Rural, Fraser Northwest, Mission, Ridge Meadows, Central Interior Rural, Central Okanagan, East Kootenay, Kootenay Boundary, South Okanagan Similkameen, Advice/Recommentations Prince George, North Shore, Vancouver, Comox Valley, Cowichan Valley Oceanside, Saanich Peninsula, Victoria, and Western Communities.

[4] Data retrieved from First Nations-led Primary Care Centres' Funding Letters and Change Requests approvals for the following FNPCCs: Lu'ma, Intergovernmental Communications Williams Lake, Intergovernmental Communications

- The ICSH Working Group has been tasked to develop tools and strategies to interrupt systemic racism against Indigenous peoples in BC, to reduce harm caused by implicit bias, and advance ICSH in primary and community care environments. The initial focus has been to begin the process to design an ICSH Engagement and Learning Pathway for community-based physicians and primary care teams. The pathway will leverage existing ICSH related materials and partnerships to improve relational and culturally safe practice(s) with Indigenous peoples.

Virtual Primary Care

- The FNHA, with Ministry funding, launched First Nations Virtual Doctor of the Day (FNvDOD) and First Nations Virtual Substance Use and Psychiatry Service (FNvSUPs).
- From implementation to January 2023, there were 28,256 FNvDOD (implemented in April 2020) and 4,149 FNvSUPs (implemented in August 2020) encounters.[5]

FINANCIAL IMPLICATIONS

The following funding was provided by the Ministry to support Indigenous Primary Care Initiatives in 2022/23:

- $15.33M to FNHA to support the Joint Project Board/Joint Priorities Board primary and provincial community care projects.[6]
- $4.71M in funding to FNHA to support FNPCCs in implementation (Lu'ma Medical Centre, Williams Lake First Nations Wellness Centre) and those commencing operations [Advice/Recommentations; Intergovernmental Communications
Advice/Recommentations;
Intergovernmental Communications
- $629,400 in funding to FNHA to support FNPCI project managers to develop service plans for future FNPCIs in various stages of active planning.[8]
- $2.37M in funding to FNHA and NHA to support FNvDOD and FNvSUPs.[9]
- *Budget 2022* allocated $45M over three years (2022/23 to 2024/25) to implement PCNs and bring additional Traditional Wellness Providers closer to Indigenous communities.

KEY BACKGROUND

- Starting in 2019, the First Nations-led Primary Health Care Initiative (FNPCI) was established between the Ministry of Health and First Nations Health Authority (FNHA) to co-fund and develop up to 15 First Nations Primary Health Care Centres (FNPCCs) within local PCNs.
- In April 2020, the Rural, Remote, First Nations and Indigenous COVID-19 Response Framework was announced to ensure people in rural/remote areas could access critical health care services. This framework has since provided guidance on initiatives and efforts to improve access to culturally safe primary care services for Indigenous peoples. These efforts include the Indigenous Cultural Safety and Humility Working Group, Joint Project/ Priorities Board and virtual primary care initiatives, in addition to PCN Indigenous partners engagement and FNPCCs.
- The FNPCC model will enable team-based, culturally safe primary health care and access to social services. FNPCC models combine both Western and Indigenous approaches, incorporating and promoting First Nations' knowledge, beliefs, values, practices, and employ holistic models of health and healing.

LAST UPDATED

The content of this fact sheet is current as of February 26, 2023 as confirmed by Jennifer Gough and Kelly McQuillen.

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division

[5] Data retrieved by the Primary Care Division from FNHA on March 14, 2023
[6] Data retrieved from 2022/23 Ministry of Health – FNHA Letter of Mutual Accountability
[7] Data retrieved from FNHA 22-23 funding letters (22/23 approved cash flow amounts) and Lu'ma's 22/23 budget as of p10
[8] Data retrieved from FNHA Project Manager funding letter issued March 25, 2022
[9] Data retrieved from NHA and FNHA 22-23 Funding Letters for Real Time Virtual Supports

LEGISLATIVE SESSION – ESTIMATES NOTE

Maternity Services Strategy

Topic: The Maternity Services Strategy (MSS) is a response to urgently address maternity services challenges in BC and has been developed through province-wide collaboration by the Ministry and Perinatal Services BC (part of the Provincial Health Services Authority). The MSS includes a series of initiatives and projects across the continuum of maternity care to stabilize, sustain and, where appropriate, expand access to team-based maternity services based on the needs of the population.

Key Messaging and Recommended Response:

- **The Maternity Services Strategy (MSS) is a three-year roadmap, developed by the Ministry of Health, Provincial Health Services Authority (PHSA), and provincial partners, that aims to improve access to perinatal services, culturally safe care, and team-based maternity care.**
- **Perinatal Services BC (PSBC) currently coordinates the collaborative implementation of the MSS.**
- **The MSS and year one activities received endorsement from key stakeholders at the November 2021 Leadership Council meeting.**
- **In March 2023, the Ministry and PHSA will seek endorsement to publish the MSS, implement a communications strategy, and gain support for the three-year roadmap.**
- **The roadmap is aligned with five future-focused, action-oriented, and scalable recommendations to enhance maternity and newborn services.**
- **Key actions include partnering with communities for culturally safe care, enhancing supports for rural and remote care, and attracting and retaining skilled providers.**
- **The MSS emphasizes adopting a quality framework to inform priorities, track progress, and establish provincial quality standards for system-level monitoring.**
- **The strategy also aims to strengthen system-wide planning and coordination, focusing on sustainable transport delivery models aligned with Maternal/Fetal and Neonatal Tiers of Service.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- The Ministry of Health, the Provincial Health Services Authority (PHSA) and provincial partners involved in the planning and provision of maternal and newborn care in BC have developed the MSS and three-year roadmap for action. The MSS has a goal to improve:
  - access to perinatal services across the continuum of care
  - access to culturally safe and trauma-informed maternity and newborn care
  - access to inter-disciplinary, team-based maternity care
- Collaborative action and implementation of the MSS is currently coordinated by Perinatal Services BC (PSBC, PHSA).
- The Deputy Minister, PSBC - PHSA, First Nations Health Authority and the regional health authorities provided endorsement of the MSS and year one activities at the November 2021 Leadership Council meeting.
- At the March 2023 Leadership Council meeting, the Ministry and PHSA will be seeking endorsement to publish the MSS and implement a communications strategy targeting perinatal providers. Direction and support for the three-year roadmap will also be sought.

Advice/Recommentations

FINANCIAL IMPLICATIONS

Advice/Recommentations

Advice/Recommentations

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Government Financial Information		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Sustainability issues persist for many of the sites offering maternity services. Communities from across the province have reported urgent workforce shortages impacting the availability of maternity services.[1]
- The MSS is expected to lead BC toward province-wide maternity services, where:
  - every individual, woman and family has access to predictable, high-quality, person-centered and culturally safe maternity care as close to home as safely possible;
  - providers are supported to work to their full scope of practice and in inter-professional collaborative teams; and
  - the system is considered holistically and planned to match services to the needs of the population.
- To address immediate sustainability concerns, the following actions have been completed to better support, attract, and retain maternity care providers:
  - An environmental scan of training options for neonatal stabilization and support for virtual training opportunities across all Tiers of Service, including the use of simulation for obstetrical emergencies, and newborn resuscitation and stabilization.
  - Enhanced access to Fetal Health Surveillance by launching a virtual health pilot for instructor training, expediting the next cohort of instructors.
  - Investigation of BC Neonatal Resuscitation Program standards and make provincial recommendations.
  - Investigated how to expedite hospital privileging for maternity services providers.
  - Rapidly review the rural/remote provider contracts to ensure adequate coverage.

LAST UPDATED

The content of this fact sheet is current as of February 27 2023, as confirmed by Jennifer Gough, Kelly McQuillen and Shana Hall, obo Shana Ooms.

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division
2023 04 05 - Kerri Harrison, Finance and Corporate Services

[1] Rural 1A Maternity Sites in BC Symposium Proceedings: Working Together for Sustainability, October 29, 2018. UBC Centre for Rural Health Research. https://med-fom-crhr.sites.olt.ubc.ca/files/2018/11/Working-Together-for-Sustainability-Proceedings.pdf. Accessed February 9, 2022.

LEGISLATIVE SESSION - ESTIMATES NOTE

Mental Health and Substance Use in Primary Care

Topic: Equitable access to quality, culturally safe, person-and-family-centred mental health and substance use (MHSU) primary care services is a key focus within the primary care strategy. This strategy was put in place to improve services for people with mild to moderate MHSU challenges, whether it be through addressing gaps in access and/or ensuring increased attachment.

Key Messaging and Recommended Response:

- **Our government is making historic investments to improve access to mental health supports, so that when people ask for help, help is available.**
- **This includes significant investments in low and no-cost counselling – including for women, Indigenous people, LGBTQ2SI+ and other underserved populations, so more people can get the help they need.**
- **BC is integrating mental health care into primary care, as of December 2022, through 32 Urgent and Primary Care Centres and 61 Primary Care Networks across BC.**
- **Both Ministries of Health and Mental Health and Addictions are committed to ongoing dialogue regarding the role of the psychologist in team-based primary care settings and how their integration into primary care networks may add capacity to improve gaps in service.**
- **To that end, both ministries have partnered together to identify options for publicly-funded counselling services, with the future support of an Advisory Committee. The BCPA was formally requested to join this Advisory Committee, to better integrate mental health and addiction services into the primary care system. This Advisory Committee, with BCPA representation, have been meeting since October 2022, and have been actively providing their insights towards informing a service model design for publicly funded counselling services. The Ministry of Health, in partnership with the Ministry of Mental Health and Addictions, is responsible for community, acute and tertiary child, youth and adult Mental Health and Substance Use (MHSU) services, along with services provided by general practitioners and psychiatrists.**

- **To address the needs of people with MHSU disorders, the ministry provides a range of services for adults in community and inpatient settings, and health prevention and promotion services. Examples include:**
    - **Hospital inpatient psychiatric services, such as Psychiatric Emergency Units;**
    - **Designated Observation Units in rural hospitals;**
    - **Specialized MHSU Tertiary Care Units which provide specialized assessments, treatment and rehabilitation services for people with complex MHSU disorders; and**
    - **Primary Care Networks (PCNs) where physicians with support from allied mental health clinicians such as social workers and nurses provide MHSU assessment, treatment and follow-up.**
- **PCNs are intended to bring together the various partners and organizations providing longitudinal and episodic primary care services in a geographic area and support them to work together to meet the needs of people in their communities, including those who need MHSU services.**
- **To ensure British Columbians are getting the comprehensive care and supports they need, the Province has launched 63 PCNs throughout BC, resulting in 236,000 new attachments since the launch of our primary care strategy.**
    - **We will continue to launch more PCNs and hire more FTEs to join them.**
- **And across all our primary health care initiatives, we have hired over 1,292 new full-time equivalent health care providers with nearly a thousand more on the way, building the health care workforce required to staff our primary care strategy.**

CURRENT SITUATION

- In a December 2020 study, 86% of British Columbians supported publicly funded psychological services in the healthcare system. Further, 41% of British Columbians believe current wait times to see publicly funded mental health care providers are unreasonable.[1]
- In September 2021, the Ministry of Health began working directly with the Ministry of Mental Health and Addictions (MMHA) to support MMHA's Mandate Letter which focuses on the need to continue to build a comprehensive system of mental health and addictions care, including by implementing *A Pathway to Hope*.

[1] Strong majority want improved access to psychologists: British Columbia. https://cpa.ca/docs/File/Media/BC%20Access%20to%20Services%20CPA%20CPAP%20Nanos%20Survey.pdf

The intersection of the Ministry's primary care strategy with MMHA's A *Pathway to Hope* has led both Ministries to collaborate on MMHA's deliverable of expanding access to counselling services.

- As of January 2023, the Ministry and MMHA have met five times with a specially convened Advisory Committee with the objective of informing Ministry and MMHA of service needs of people with lived and living experience and to hear from other organizations on how to effectively deliver services.
- As part of the primary care strategy, as of January 2023, 63 Primary Care Networks (PCNs) are now in implementation with 59 of these (94%) successfully recruiting staff with MHSU specific classifications to ensure increased access to MHSU services. Further, primary care initiatives funded under the strategy have recruited 1,416 full-time equivalents (FTEs) of 2,189.3 (68.5%) approved FTEs across 260 clinics and regional hubs.[2] Of those, 232 FTEs (e.g., see table) are delivering dedicated MHSU services, with more expected as the number of PCNs, Urgent and Primary Care Centres (UPCCs), Community Health Centres (CHCs) and others continues to grow. [3]

As of January 2023 (P10), the 232 FTE hires offering MHSU services are, by initiative and by region:

	PCN		CHC		FNPCC		NPPCC		UPCC	
FTE	Approved	Actual	Approved	Actual	Approved	Actual	Approved	Actual	Approved	Actual
Clinical Counsellor	7.5	50.0	1.5	1.5	1.5	0.0	0.0	0.0	12.0	5.0
Life Skills Worker	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MHSU Clinician	48.3	34.8	1.0	8.8	4.4	0.0	3.0	1.4	25.4	11.3
MHSU Support	0.0	20.0	0.0	0.5	0.0	0.0	0.0	0.0	0.9	4.3
Outreach Worker	0.0	5.4	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0
Psychologist	2.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Social Prog. Officer	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	21.6
Social Worker	77.6	57.5	5.5	3.5	2.5	1.8	3.0	1.4	31.9	0.0
Grand Total	**135.4**	**168.7**	**8.0**	**16.3**	**8.4**	**1.8**	**6.0**	**2.8**	**70.2**	**42.2**

Regional highlights of focused MHSU strategies in primary care:

- *Vancouver Coastal Health:* RISE CHC provides services to patients with mild to moderate MHSU including counselling and therapy programs, case management, support groups, and advocacy; Lu'ma Medical Centre (First Nations Primary Care Centre) provides MHSU support for primarily urban Indigenous people; the North Shore PCN has the Health Connections Clinic and Foundry Centre; all UPCCs in the region include MHSU support.
- *Fraser Health:* The Fraser Northwest PCN has a Rapid Access Mental Health Program; Burnaby PCN has a Mild to Moderate Mental Health Program; Ridge Meadows PCN has developed a Wellness Centre which offers Adult Mental Health Services; White Rock South Surrey PCN has a Primary Care Access Clinic which provides support to vulnerable patients; and all UPCCs in the region include MHSU support.
- *Interior Health:* The Penticton UPCC in the South Okanagan Similkameen PCN offers primary care, specialized services for those experiencing moderate to severe MHSU challenges; the Vernon UPCC provides specialized services to support those experiencing MHSU challenges; 3 PCNs (Cranbrook, Kelowna, and Penticton) have Foundry Centres; and all UPCCs and PCNs in the region include MHSU support.
- *Island Health:* Island Sexual Health CHC offers brief short-term counselling, conducts assessments, and offers referrals to community services for those presenting with MHSU issues; the Nanaimo UPCC includes timely access to Opioid Agonist Therapy; the Victoria PCN has direct linkages to Foundry Victoria to provide primary

[2] FY2022/23 Period 10 Workforce Hiring Report, Results Management Office, Primary Care Division, Ministry of Health, January 5, 2023.
[3] Intergovernmental Communications

care for the youth population; the Campbell River and District PCN has been approved resources to support primary care for the youth population at Foundry; and all UPCCs and PCNs include MHSU support.

- *Northern Health:* interprofessional teams offer mental health in community settings in 23 communities in the North. Funding has been provided to support hiring of MHSU health care professionals in the Prince George and Northern Interior Rural (NIRD) PCNs and the Quesnel UPCC. As well, the Carrier Sekani Family Services Foundry has been provided funding for MHSU through the NIRD PCN.

FINANCIAL IMPLICATIONS

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		Government Financial Information
Budget 2023*	$399.1			
Grand Total	**$679.4**			**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

- Major depressive disorder and generalized anxiety disorder are recurring mental health conditions affecting approximately 450,000 British Columbians each year.[4] In fiscal year 2020/21, 338,024 people in BC received services for anxiety disorders and 229,333 received services for depression.[5]
- The Ministry's PCN policy direction outlines a requirement to provide comprehensive primary care services, which includes MHSU services such as screening, assessment, and management of mild to moderate conditions, as well as outlining the expectation to ensure effective transitions of care as appropriate to the nearest specialized community services program when more specialized care is needed.
- The primary care strategy has already enabled new MHSU resources and better integration of services for those with mild to moderate MHSU, and via linkages with specialized community service programs.

LAST UPDATED

The content of this fact sheet is current as of March 7, 2023, confirmed by Shana Hall obo Shana Ooms, and Jennifer Gough.

APPROVALS

2023 03 28 - Lenore Ogilvy obo Martin Wright, Health Sector Information, Analysis and Reporting Division
2023 03 29 - Brenda Rafter obo Rob Byers, Finance and Corporate Services Division
2023 03 31- Ted Patterson, Primary Care Division

[4] Centre for Clinical Epidemiology and Evaluation, Abridged HTA [Health Technology Assessment] for psychotherapy, April 15, 2021
[5] Health Sector Information, Analysis and Reporting Health System Performance Portal. https://hspp.hlth.gov.bc.ca/framework/service-delivery/specialized-community-services/mental-health-substance-use-service

LEGISLATIVE SESSION - ESTIMATES NOTE

Nurse Practitioners in Primary Care

Topic: Nurse Practitioners (NPs) are an integral part of the Ministry of Health's primary care strategy. As independent providers with an extensive scope of practice, NPs play an important role in increasing access to longitudinal primary care for British Columbians through Primary Care Networks (PCNs). A unique service model under the primary care strategy, NP Primary Care Clinics (NPPCCs) are developed by NPs who work within a collaborative, team-based environment and as part of local PCNs. NPPCCs help support communities where a large part of the population has difficulty accessing a regular primary care provider – either a Family Physician (FP) or NP.

Key Messaging and Recommended Response:

- **The integration of Nurse Practitioners (NPs) in BC's primary care strategy is helping address the growing demand for primary care services, allowing more patients to receive timely and accessible care.**
- **NPs are highly trained to provide a wide range of services, including diagnosing and treating illnesses, prescribing medications, and ordering diagnostic tests. Their inclusion in primary care teams allows for a more comprehensive and holistic approach to patient care.**
- **The presence of NPs in primary care settings fosters a collaborative and team-based approach, where NPs work alongside physicians, pharmacists, and other health professionals to deliver well-coordinated and efficient care to patients. This collaboration ultimately improves patient outcomes and satisfaction.**
- **As of January 2023, across all primary care initiatives underway, 1,426 of the 2,184 approved full-time equivalents (FTEs) have been recruited and placed into 260 clinics. Of the 2,184 overall approved FTEs, 321.6 of these are NP FTEs, with 227 FTE NPs having been recruited, either using a Primary Care Network (PCN) NP Contract or as health authority salaried staff.**
- **PCN NPs have attached at least 64,870 patients to date.**
- **The NPPCC model of care became operational in Nanaimo, Victoria, and Surrey in 2020 as part of the approach to improve access to longitudinal, team-based primary care services. The three NPPCCs have attached 9,711 patients as of January 2023.**

LEGISLATIVE SESSION - ESTIMATES NOTE

CURRENT SITUATION

- As of January 2023, across all primary care initiatives underway, 1,426 of the 2,184 approved full-time equivalents (FTEs) have been recruited and placed into 260 clinics. Of the 2,184 overall approved FTEs, 321.6 of these are NP FTEs, with 227 FTE NPs having been recruited, either using a PCN NP Contract or as health authority salaried staff.[1]
- New FTE NP positions are expected to attach and carry a panel of 1,000 patients. Panel sizes may be reduced for NPs practicing in rural areas and/or attaching priority/complex populations.
- PCN NPs have attached at least 64,870 patients to date.[2]
- The NPPCC model of care became operational in Nanaimo, Victoria, and Surrey in 2020 as part of the approach to improve access to longitudinal, team-based primary care services. The three NPPCCs have attached 9,711 patients as of January 2023:[3,4]

Health Region	Primary Care Network	NPPCC	Date Opened	Number of Attachments
Fraser	Surrey-North Delta	Surrey (Axis PCC)	August 10, 2020* & September 8, 2020	2,812
Island	Nanaimo	Nanaimo (Nexus PCC)	June 30, 2020	2,745
Island	Victoria	Victoria (Health Care on Yates)	August 10, 2020* & September 28, 2020	4,154

* Virtual opening dates

- As of January 2023, the three NPPCCs are fully operational with 17.0 FTE NPs, 5.9 FTE Registered Nurses (RNs), and 6.0 FTE allied health hired in total.[5]
- While not one of the three NPPCCs, the Flowerstone Family Health Clinic (Qualicum Beach, Island Health, operational October 1, 2020) follows a very similar model to the NPPCCs. An operational plan for this clinic was submitted and approved as part of the Oceanside PCN Service Plan, indicating support for this model within PCN planning processes. As of January 2023, this clinic has attached approximately 2,890 patients.[6]

FINANCIAL IMPLICATIONS

As of January 2023, annual ongoing operating funding approved for the NPPCCs and the Flowerstone Family Health Clinic are shown below, along with one-time funding for start-up costs and change management:

	Nanaimo	Surrey	Victoria	Flowerstone Family Health Clinic**
Annual Operating Funding	$2,016,661	$2,000,000	$2,000,000	$1,810,620
One-time Change Management*	$180,000	$180,000	$180,000	
One-time Start-up	$495,500	$754,416	$445,500	$1,401,138
Total	**$2,692,161**	**$2,934,416**	**$2,625,500**	**$3,211,758**

*$60K/year over 3 years for Nanaimo, Surrey & Victoria

**The Ministry of Health flowed $1,401,137 to Flowerstone through the Vancouver Island Health Authority (VIHA), consistent with news release: https://news.gov.bc.ca/releases/2022HLTH0003-000096. In 2022, $106,450 was recovered from Flowerstone by VIHA for unspent TI funds.

KEY BACKGROUND

- As primary care providers, NPs can independently manage a panel of patients, conduct assessments, diagnose, prescribe medications, order and interpret tests, initiate referrals to specialists, perform minor procedures, and collaborate with an interdisciplinary team of providers to meet patient needs.

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[1] Ministry of Health, RMO Workforce Report from period financial data, FY 2022/23, P10 to January 5, 2023
[2] HSWBS, Nursing Policy Secretariat. Data extracted from MSP database on February 10th, 2023 as of February 10th, 2023.
[3] Ministry of Health, Results Management Office (RMO), Primary Care Division. VIHA and FHA Approval Trackers (FY 2022/23). February 15, 2023.
[4] Ministry of Health, Nursing Policy Secretariat, Clinic self-reported attachments (sent directly to the Ministry). December 2022.
[5] Ministry of Health, RMO Primary Care Workforce Report, from financial period submissions, FY2022/23 P10. January 5, 2023.
[6] Ministry of Health, Health Sector Information, Analysis and Reporting (HSIAR), Primary Care Acute Care and Workforce Analytics, MSP Database. Extracted Feb 27, 2023.

- The PCN NP Contract is a mechanism to integrate NPs into primary care as independent practitioners and requires practitioners to agree to become part of the PCN in their community and to adopt the attributes of the Patient Medical Home (PMH).[7]
- Each NPPCC is funded to provide longitudinal, team-based primary care services delivered by a team comprised of:
    - 5.8 FTE NPs (+0.2 FTE Clinical Director);
    - 2.3 FTE RNs, including relief;
    - 1.0 FTE Social Worker; and
    - 1.0 FTE Mental Health Worker.
- It is anticipated over 20,000 patients (6,800 per site) will ultimately be attached to a primary care NP as a result of the NPPCC initiative (consistent with NP attachment targets in PCN clinics). This number is intended to be reached three years after the opening date for each clinic: i.e., in summer/fall of 2023.
- The Ministry of Health has been working collaboratively with local Divisions of Family Practice and health authorities to support integration of the NPPCCs in PCN planning at the community level.
- To support provincial consistency of performance monitoring, reporting requirements for NPPCCs will follow the same evaluative criteria as PMHs and Urgent and Primary Care Centres.
- The initial focus of PCNs is to support increased attachment to a Most Responsible Provider through the addition of new-to-practice FPs and NPs who will provide longitudinal "attached" primary care to those who are considered unattached, thereby closing the attachment gap.

LAST UPDATED

The content of this fact sheet is current as of March 1, 2023, by Shana Hall obo Shana Ooms and Kelly McQuillen.

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division
2023 04 13 - Eric Larson obo Martin Wright, Health Sector Information Analysis and Reporting Division
2023 04 17 - Kerri Harrison obo Rob Byers, Finance and Corporate Services Division

[7] Patient Medical Home in BC http://www.gpscbc.ca/sites/default/files/PMH%20graphic%20%2020160920.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

New-to-Practice Incentives Program

Topic: The Ministry of Health established the New to Practice (NTP) Incentives Program for family physicians (FPs) in 2022 as a contracting option for NTP FPs who have recently completed their family medicine residency program and wish to provide full-service, longitudinal primary care.

Key Messaging and Recommended Response:

- **The New To Practice (NTP) Program has successfully attracted 120 new doctors to provide full-service primary care in communities across BC as of February 25, 2022.**
- **Launched in June 2022, the program offers attractive incentives to recent family medicine graduates, including a competitive first-year salary, signing bonus, medical training debt forgiveness, and overhead cost contributions for host clinics.**
- **The incentives are offered to all family medicine residents and NTP family physicians (FPs) who completed their medical residencies in 2021 or 2022.**
- **The NTP contract rate is $325,620 per full-time equivalent (FTE):**
    - **An additional $75,000 overhead payment is available for the hosting clinic per FTE;**
    - **$25,000 signing bonus;**
    - **$50,000 loan forgiveness payment; and,**
    - **Potential for additional contributions to loan forgiveness of $20,000 per year for years two to five.**
- **In addition to the 120 signed contracts, over 201 family physicians are currently in discussions regarding suitable clinic placements and contract terms.**
- **On average, the UBC Faculty of Medicine graduates 174 doctors per year from residency. As part of our Health Human Resources Strategy the family medicine residency program will increase from 174 to up to 214 by 2024-25.**
- **The incentives are part of the broader Provincial Primary Care Strategy, which included $118 million in stabilization funding to support family doctors, and funding for the New Longitudinal Family Practice Model and the continued implementation of the Province's team-based Primary Care Strategy.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- The NTP Incentives Program was announced June 15, 2022. The contract package was made available to physicians starting August 16, 2022 and will continue to be offered at least through 2023/24.
- The incentives are offered to all family medicine residents and NTP FPs who completed their medical residencies in 2021 or 2022:
  - $325,620 NTP contract rate per full-time equivalent (FTE);
  - An additional $75,000 overhead payment for the hosting clinic per FTE;
  - $25,000 signing bonus;
  - $50,000 loan forgiveness payment; and,
  - Potential for additional contributions to loan forgiveness of $20,000 per year for years two to five.
- Under the contract, FPs are required to attach patient panels of 1250 per FTE. The minimum FTE requirement is 0.5 FTE, and incentives are pro-rated based on the FTE proportion.
- 201 Expressions of Interest have been received between August 16, 2022 and February 25, 2023.
- As of February 25, 2023, 120 NTP Contracts have been signed since June 15, 2022.
- 38 NTP Contracts are with Canadian Medical Graduates and 82 are International Medical Graduates.

Status of NTP Incentives Program Contracts[1] From June 15, 2022 to February 11, 2023

Region	Expressions of Interest	Total Contracts Signed
Fraser Health Authority	55	45
Interior Health Authority	31	17
Northern Health Authority	14	0
Vancouver Coastal Health	50	32
Vancouver Island Health Authority	50	26
TBD *Regional health authority not yet assigned.*	1	0
Provincial	201	120

- Of the practitioners on contracts signed since June 15th, 2022, data for the 114 who have had billed services as of February 28th, 2023 includes:[2]
  - Total Services Across All NTP Practitioners = 286,357
  - Total Unique Patients Seen Across All NTP Practitioners = 62,494
  - Total Unique Patients with $0 Attachment[3]** = 30,072

FINANCIAL IMPLICATIONS

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Intergovernmental Communications		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Intergovernmental Communications		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

- Throughout 2022 the Ministry and Doctors of BC were actively involved in discussions on a range of issues related to the sustainability of family medicine as the foundation of primary care in our province. Many of the challenges that need to be addressed are longstanding and common in jurisdictions throughout Canada, and there are a number of different perspectives among physicians and other partners on potential solutions.

[1] New-to-Practice Incentives Program Update report – February 11, 2023

[2] Update provided via email February 8, 2022 from Director, Primary Care and Workforce Analytics, HSIAR

[3] Note: of the 114 practitioners that have billed MSP as of February 28th, 2023, 99 have billed at least one (1) $0 Attachment Code.

- Through this dialogue, it was made clear to the Ministry that immediate action must be taken in the short term while longer term solutions are being developed. The incentives offered to family medicine residents and NTP FPs should be considered as one element of what will be a broader and more comprehensive suite of short, medium and long-term actions identified by the Ministry and Doctors of BC.
- The NTP Incentives Program was announced June 15, 2022. The contract package was made available to physicians starting August 16, 2022 and will continue to be offered at least through 2023/24.
- All NTP FPs who completed their medical residencies in 2021 or 2022 are eligible for the incentives outlined above, noting eligibility going forward will be extended to the medical resident cohort completing in 2023. This also includes international medical graduates (IMGs) who completed their family medicine residency through the IMG-BC program.
- For the loan forgiveness payments, eligible loans will include both government-sponsored student loans as well as private loans or lines of credit. The candidate will need to demonstrate a loan is associated with medical education and training and provide the amount of the outstanding loan as of the start of the NTP service contract.
- In addition to the individual incentives, the Ministry will also provide an overhead contribution of $75,000 per FTE per year to each clinic hosting a NTP FP under this arrangement. This payment is intended to significantly reduce or in some cases eliminate the amount of overhead the NTP will be required to contribute to their host clinic.
- The Ministry of Health will continue to offer the incentives in review in 2023 and will review their effectiveness going forward to determine whether they will continue beyond 2023.
- There are no limits on the availability of NTP service contracts for communities provided that the parties work in good faith to meet the terms of the contracts, particularly the attachment expectations.

LAST UPDATED

The content of this fact sheet is current as of March 5, 2023 as confirmed by Jennifer Gough, and Kelly McQuillen

APPROVALS

2023 03 10 – Ted Patterson, Primary Care Division
2023 04 06 – Eric Larson obo Martin Wright, Health Sector Information Analysis and Reporting Division

LEGISLATIVE SESSION – ESTIMATE NOTE

Primary Care Attachment (Data)

Topic: Patients who are "attached" to a regular care provider, team, or place of care where there is a continuous relationship over time are more satisfied with their care and consistently show improved health outcomes, decreased mortality, and reduced health care costs, particularly for those with complex health care needs.[1,2,3] A central goal of the primary care strategy is to ensure that people in BC have access to a regular primary care provider such as a Family Physician (FP) or Nurse Practitioner (NP), and/or to a regular team of providers.

Key Messaging and Recommended Response:

- **The Province of BC has been working diligently to increase access to primary health care by supporting stronger and long lasting relationships with family doctors and nurse practitioners.**
- **While historical data from the Canadian Community Health Survey (CCHS) has shown a downward trend in attachment rates between 2003 and 2021, recent efforts have resulted in a 2.1% increase in the number of people identifying as attached between 2020 and 2021.**
- **We expect that trend to continue based on the significant changes we have made through the introduction of new compensation models to recruit and retain physicians, such as the Longitudinal Family Physician (LFP) and New-to-Practice (NTP) Incentives program, and continued funding for the Alternative Payments Program (APP) and Group practice Contracts provided in support of the strategy.**
- **To enhance the accuracy of reporting on attachment rates in BC, the Doctors of BC and the Ministry of Health are collaborating to develop and implement a new Patient Rostering system by July, where doctors will submit their patient panels to identify capacity in the system and attach patients seeking attachment to a primary care provider.**
- **This innovative approach will not only support planning but also track new attachments related to primary care initiatives.**
- **Through the primary care strategy, the Ministry has funded 2,184 clinical and administrative full-time equivalents (FTEs), including 371 FPs, 322 NPs, and 663 nurses.**

[1] Starfield, Barbara. 1992. Primary Care: Concept, Evaluation and Policy.
[2] Berry, Leonard et al. 2008. Patients' Commitment to Their Primary Physician and Why It Matters. Ann Fam Med, 6(1).
[3] General Practice Services Committee (GPSC). 2017. Evidence Summary: The Benefits of Relational Continuity in Primary Care.

- **As of January 2023, 263,917 British Columbians have been newly attached to a primary care provider or practice in a Primary Care Network (PCN) across all clinical service models.**
- **This reflects the Province's ongoing commitment to improving its data on attachment rates and enhancing the accessibility of primary care services for the residents of BC.**

CURRENT SITUATION

- While the Doctors of BC and the Ministry of Health work to develop and implement an "Attachment Management System", which includes a provincial patient rostering system that will enable more accurate reporting on attachment in BC, other measures are in place to estimate attachment to support planning and to track new attachments related to primary care initiatives.[4]
- The Canadian Community Health Survey (CCHS) data on attachment from 2003 to 2021 suggests an overall downward trend over time in the number of people (aged 12+) identifying as having a regular primary care provider in BC, from 89.4% in 2003 to 83.0% in 2021. Stated differently, the number of people identifying as not attached in BC has increased from 10.6% in 2003 to 17.0% in 2021.
- Of note however, between 2020 and 2021, there was a 2.1% increase in the number of people identifying as attached. [5]
- 10.1% of respondents to the 2021 CCHS indicated they were actively seeking a regular provider. When this percentage is applied to the 2021 BC population, just under 525,000 people are actively seeking a provider.[6,7]
- Patient attachment estimates using the BC Attachment Algorithm (physician billing data from MSP) show that 77.2% (4,220,504) of British Columbians were attached and 12.1% (663,598) were unattached in 2021/22. For the remaining 10.7% (585,088), the attachment status could not be determined.[8]
- Using the Attachment Algorithm, the number of people unattached to an FP/NP practice varies by health region as follows: Fraser (237,222); Vancouver Coastal (145,025); Interior (106,187); Vancouver Island (119,124); Northern (51,635). There are also 4,405 unattached residents whose health authority is unknown.[9]
- To date, through the primary care strategy the Ministry has funded 2,184 clinical and administrative full-time equivalents (FTEs), including 371 FPs, 322 NPs, and 663 nurses to close the attachment gap. As of January 2023, 65% of all funded FTEs (1,426.4) have been recruited.[10]
    - Recruitment of FPs in Primary Care Networks (PCNs) has historically been challenging; however, hiring of FPs significantly improved since the launch of the New to Practice (NTP) incentives program initiative in June 2022, with an additional 67.5 NTPs hired into PCNs across the province. The total number of FPs hired (in PCN service contracts, combined with the NTP initiative contracts) in all PCNs is 162.7 FTEs; 74% of the overall Service Plan approved total of 221.1 FP FTEs.[12]
    - Progress has been made recruiting NPs and nurses, with 227 of 324.6 FTE NPs (70% of target) and 424.9 of 670.5 FTE nurses (63% of target) hired.[12]

[4] https://news.gov.bc.ca/releases/2022HLTH0212-001619
[5] Statistics Canada. Canadian Community Health Survey. 2021. Table 13-10-0096-16 Has a regular healthcare provider, by age group. Last accessed Feb 22, 2023.
[6] Ibid.
[7] Ministry of Health, Health Sector Information, Analysis and Reporting (HSIAR). Population data is from P.E.O.P.L.E. 2021 (BC Stats) and may differ from other Ministry estimates.
[8] Ministry of Health, HSIAR, Primary Care Acute Care and Workforce Analytics, Client Roster Database, 2021/22. Extracted Feb 17, 2023.
[9] Ministry of Health, HSIAR, Primary Care Acute Care and Workforce Analytics, Client Roster Database, Client Geography Table. Extracted Feb 17, 2023.
[10] Ministry of Health, Results Management Office, Primary Care Workforce Report - FY22/23 P10, January 5, 2023

- As part of PCN service contracts, FPs and NPs are expected to progressively grow their panels to 1,250 and 1,000 respectively over a period of two years. While registered nurses (RNs) do not attach patients, they are expected to support increased panel sizes for FPs/NPs by up to 500 additional patients.
- As of January 2023, 263,917 British Columbians have been newly attached to a primary care provider or practice in a PCN (across all clinical service models).[11]

Region	Newly Attached
Fraser	87,978
Interior	39,401
Northern	1,911
Vancouver Coastal	72,911
Vancouver Island	61,716
TOTAL	**263,917**

- The Health Connect Registry (HCR) provides information about patients needing attachment. As of January 5, 2023 (Period 10) , the HCR was live in 21 PCN communities or regions; there were 105,909 registrants on the HCR, of which 18,938 registrants have been successfully attached to a primary care provider. An additional 9,471 patients were attached in the Kamloops area using the original waitlist prototype prior to launching the HCR (totalling 28,409 attachments).[12] (See Health Connect Registry Estimates Note)

FINANCIAL IMPLICATIONS

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Government Financial Information		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

- Patient attachment estimates using the BC Attachment Algorithm show a slight improvement in 2021/22 versus the previous five years, from 75.9% in 2017/18 to 77.2% in 2021/22.[13]
- Several factors influence primary care capacity and patient attachment, including increased population growth (est. 1.43% between 2019-2029), redeployment of resources to support the COVID-19 response, number of FPs offering longitudinal care (i.e., 4,129 or 58.7%), panel complexity reducing the number of patients per panel (e.g., the number of persons with major chronic conditions increased from 199,900 in 2012/13 to 289,000 in 2021/22), and an aging/retiring workforce (36.3% of FPs are 55+).[14,15,16,17]
- Through the Family Practice Services Committee, the Province is funding incentives to physicians providing longitudinal care including a Community Longitudinal Family Physician Payment (up to $12,000) to recognize the non-clinical responsibilities of longitudinal care, a new patient intake fee ($15), a one-time panel

[11] Ministry of Health, HSIAR, Primary Care Acute Care and Workforce Analytics, Medical Services Plan (MSP) Database. Extracted Feb 15, 2023.
[12] Ministry of Health, HealthLink BC, HCR – P2, up to May 26, 2022.
[13] Ministry of Health, HSIAR, Primary Care Acute Care and Workforce Analytics, Client Roster Database, 2021/22. Extracted Feb 17, 2023.
[14] Health System Performance Portal – Population Statistics 2017-2041. Last accessed April 3rd, 2023.
[15] Health System Performance Portal – Primary Care Attachment, Family Physicians and Visits. Last accessed April 3rd, 2023.
[16] Health System Performance Portal – Morbidity Profiles. Last accessed April 3rd, 2023.
[17] Ministry of Health, HSIAR, Primary Care Acute Care and Workforce Analytics, MSP Database. Extracted Feb 22, 2023.

management bonus payment ($3,000), and a Health Data Coalition Discover payment ($1,000) to support quality improvement in family practice. [18,19,20]

LAST UPDATED

The content of this fact sheet is current as of March 1, 2023, as confirmed by Shana Ooms, Kelly McQuillen, and Jennifer Gough.

APPROVALS

2023 04 06 - Eric Larson obo Martin Wright, Health Sector Information Analysis and Reporting Division.
2023 04 13 - Kerri Harrison obo Rob Byers, Finance and Corporate Services Division
2023 04 24 – Ted Patterson, Primary Care Division

[18] https://gpscbc.ca/sites/default/files/uploads/2021-Community-Longitudinal-Family-Physician-Payment-CLFP%20Payment-FAQ.pdf
[19] https://gpscbc.ca/news/what-we-do/incentives/new-fees-support-team-based-care-coordination-of-care-and-new-patient
[20] https://gpscbc.ca/what-we-do/system-change/panel-management

LEGISLATIVE SESSION – ESTIMATES NOTE

Primary Care Maternity Services

Topic: Various health sector partners have signaled that urgent attention is required to ensure people in BC have access to quality primary care maternity services.[1] The Ministry of Health and Perinatal Services BC (part of the Provincial Health Services Authority [PHSA]) have developed a provincial Maternity Services Strategy that includes a number of important actions to supporting primary care providers and enhancing the delivery of primary care maternity services in BC.

Key Messaging and Recommended Response:

- **Building a sustainable and resilient system of perinatal care that attracts and retains an interdisciplinary network of perinatal and newborn providers is a key focus for the Ministry so that more patients can access care when and where they need it.**
- **As part of our commitment to maternity care throughout the province, the Ministry is working in collaboration with Perinatal Services BC, Doctors of BC, regional health authorities and other partners on a provincial Maternity Services Strategy (MSS), which includes long-term options to better support maternity care providers and enhance the delivery of care to low-risk maternity patients in the community.**
- **We've developed a Health Human Resources (HHR) strategy, announced in fall 2022, that addresses many of the issues that affect health care workers, including midwives.**
- **The HHR Strategy focuses on 70 key actions to recruit, train, and retain health-care workers while redesigning the health-care system to foster workplace satisfaction and innovation. Implementation of these actions started in 2022 and continues through 2023.**
- **Some of the actions that directly impact midwives include:**
    - **Adding 20 seats to UBC's midwifery program, bringing the total annual intake to 48.**
        - **12 seats are being added to the Bachelor of Midwifery program, bringing the total annual intake from 20 to 32.**

[1] Partners include: Doctors of BC via the Joint Clinical Committees, the Midwives Association of BC (MABC), the Rural Coordinating Centre of BC (CyBC), Regional Health Authorities, First Nations Health Authority (FNHA), Provincial Health Services Authority (PHSA), researchers, providers and patients.

- **Eight seats are being added to the Internationally Educated Midwifery Bridging Program, bringing the total annual intake to 16.**

- **For Registered Nurses (RNs) interested in becoming midwives, UBC has developed an Advanced Placement Plan, which enables RN applicants to reduce the 142 credit program by 27 hours.**

- **The Ministry will work with the BC College of Nurses and Midwives, the College of Physicians and Surgeons, and other stakeholders to review existing privileging processes. This action aims to create a provincial approach to privileging that will ensure providers have flexibility to practice in hospital across regional health authorities.**
- **In addition, we are working with partners including First Nations Health Authority to explore ways to support Indigenous midwifery in areas such as reclamation of Indigenous birthing practices and Indigenous remote birthing.**
- **The Ministry is currently in negotiations with the Midwives Association of BC, and we will continue looking for opportunities to work with our partners at the BC College of Nurses and Midwives to support health-care workers.**

CURRENT SITUATION

- Recruitment and retention of primary care maternity service providers is a significant challenge:
  - Over time, the number of Family Physicians (FPs) providing birth delivery services has declined consistently from 891 (2010/11) to 656 (2020/21) and 614 (2022/23) due to workforce and system barriers such as the 24-hour nature of perinatal care and the incompatibility of fee-for-service compensation and other current compensation models for FPs. This has increased the delivery volume and on-call burden for a smaller number of FPs, Registered Midwives (RMs), and Obstetricians (OBs).[2,3]
  - Of the 535 midwives registered to practice in the province, 350 are actively practicing.[4]
- The PHSA, together with the Ministry, has developed a provincial Maternity Services Strategy (MSS) aimed at stabilizing, sustaining, and, where appropriate, expanding access to team-based maternity services [Not announced]. Advice/Recommentations

Advice/Recommentations

- In February 2023, the Ministry launched a new Longitudinal Family Practice Payment Model. A major priority for the Ministry and Doctors of BC will be to expand the model to incorporate in-hospital maternity services provided by longitudinal family physicians, to ensure this integral part of longitudinal practice is incentivized appropriately. The Ministry and Doctors of BC are working to have this work completed in 2023.
- The Ministry is also currently in negotiations with the Midwives Association of BC Advice/Recommentations

Advice/Recommentations

[2] Data as of February 14, 2023 with 2022/23 data as of January 5, 2023 service date. Extracted February 14, 2023 from MSP by HSIAR. RMS task HSIAR0003545.
[3] Ibid.
[4] Received from the BC College of Nurses and Midwives January 31, 2023.

- While the bulk of initial resources in Primary Care Networks (PCNs) are directed at improving primary care attachment and access, 14 PCNs are using funding to hire maternity providers or increase the number of providers who include maternity within their practices.[5]
    - The Ministry is currently developing a policy to provide concrete direction and guidance to PCN partners on the expectations regarding delivery of maternity services in a PCN.
- Alternative Payment Program (APP) service contracts are in place to ensure delivery of midwifery maternity services in six rural and/or indigenous communities: Hazelton, Haida Gwaii, Invermere, Salt Spring Island, Port Hardy and Powell River (See Midwives fact sheet, HSWBS). Increases to APP service contracts for each site is aimed at ensuring adequate cross coverage and prevent burnout among participating RMs.
- Family Practice Services Committee (FPSC) fee code incentives are in place to increase the provision of maternity services by FPs:
    - *$50 Maternity Risk Assessment Fee* to support FPs conducting a patient Maternity Risk Assessment.
    - *Fees for obstetric deliveries and hospital first visit bonuses* increased by 30% in September 2019 to recognize the role of FPs in providing maternity care and in-patient care in hospitals.[6]
    - *MC4BC (Maternity Care for BC)* program (launched 2008) offers a stipend up to $33,383 per FP to enhance obstetrical skills and experience through hands-on training and peer mentorship.
    - *The Maternity Network Incentive* provides a quarterly payment of $2,100 to cover the costs of group/network activities for shared care of obstetric patients.
- In October 2022, the FSPC launched a call for applications for one-time funding for FP engagement to make maternity and newborn care part of PCN/community planning discussions. Up to $1M has been allocated to this initiative. As of February 2023, 21 out of 35 Divisions of Family Practice have applied.

FINANCIAL IMPLICATIONS

A detailed 3-year roadmap for the MSS (2022/23 – 2024/25) has been developed Advice/Recommentations

Advice/Recommentations

KEY BACKGROUND

- Over the last five years (2018-2022), an average of 43,187 babies were born annually in BC.[7] Pregnant persons receive medical care from a range of maternity practitioners, including FPs, RMs, and OBs.
- Sustainability issues persist for many sites offering maternity services. Closing smaller sites on a permanent or temporary basis (diversion) has had a cascading effect, increasing workload and service delivery pressure on larger referral centres, further adding to instability. Over the past twenty years, 23 rural maternity sites have closed due to provider attrition, the incompatibility of fee-for-service compensation in low-volume birth settings, low nursing and physician confidence, under-developed networks for maternity care providers and the 24-hour nature of the service.[8]
- Low-risk maternity care is included in the overall suite of comprehensive services that PCNs are expected to deliver. In addition, PCNs provide related services including sexual health promotion, preconception counselling, and health promotion services through all stages of the perinatal period. They also provide access to contraception, abortion services and post-abortion care.
- Caesarean births in BC are the highest in Canada and have increased steadily over the past 20 years. In 2010/21, 39% of hospital deliveries for BC residents were by caesarean (compared to 30% across Canada) and 24% of low-risk deliveries for BC residents occurred by caesarean (compared to 18% federally).[9,10]

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[5] Maternity Services Scan of Primary Care Initiatives (PCIs). Primary Care Division. As of November 2022.
[6] Family Practice Services Committee (FPSC). Accessed on April 7, 2022: http://fpscbc.ca/news/news/gpsc-increases-maternity-and-hospital-fees
[7] BC Vital Statistics Agency. Births by Community Health Service Area, 2017 to 2021 Reports: https://www2.gov.bc.ca/gov/content/life-events/statistics-reports/births. Accessed February 13, 2023.
[8] Centre for Rural Health Research: https://med-fom-crhr.sites.olt.ubc.ca/files/2018/11/Working-Together-for-Sustainability-Proceedings.pdf. 01/26/22.
[9] Canadian Institute for Health Information. Hospitalization and Childbirth, 1995–1996 to 2020–2021 — Supplementary Statistics. Ottawa, ON: CIHI; 2021. HSIAR data collection: February 13, 2023.
[10] Canadian Institute for Health Information. Low-Risk Caesarean Sections details for British Columbia. Your Health System. Accessed on February 23, 2023. HSIAR data collection: January 26, 2022.

- The Ministry took a number of steps to ensure ongoing delivery of maternity services during the COVID-19 pandemic. For example, since 2020, the Ministry has provided funding support to the Maternity and Baby Advice Line (MaBAL), which offers rural, remote, and Indigenous primary care providers with 24/7 virtual access to FPs with expertise in maternal/newborn care. From August 2020 to December 2022, MaBAL received a total of 2,353 calls.[11]

LAST UPDATED

The content of this fact sheet is current as of February 27, 2023 as confirmed by Jennifer Gough, Kelly McQuillen and Shana Hall obo Shana Ooms.

APPROVALS

2023 02 24 - Shana Hall obo Shana Ooms, Strategy, Policy and Quality, Primary Care Division
2023 03 10 - Ted Patterson, Primary Care Division
2023 03 31 - Eric Larson obo Martin Wright, Health Sector Information Analysis and Reporting Division.

[11] Data received from the Rural Coordination Centre of BC on February 15, 2023.

LEGISLATIVE SESSION - ESTIMATES NOTE

Primary Care Networks

Topic: Primary Care Networks (PCNs) are geographically based, locally planned, and coordinated systems of primary care, where physician-owned Family Practices, Urgent and Primary Care Centres, Community Health Centres, First Nations Primary Health Care Centres, and Nurse Practitioner Primary Care Clinics are networked with each other to provide comprehensive longitudinal and episodic primary care services.

Key Messaging and Recommended Response:

- **As of January 2023, 63 Primary Care Networks (PCNs) have been launched by the Ministry of Health, covering 73% of Community Health Service Areas (CHSAs) and 85% of the provincial population.**
- **The Ministry plans to have approximately 99 PCNs covering the entire geography of the province by 2025.**

Advice/Recommentations; Government Financial Information

  - **Of this, approximately $245M supports annual operating costs for 63 PCNs currently in implementation.[1] The Ministry's target is to have approx.** Advice/Recommentations

Advice/Recommentations

- **To date, a total of 896 full-time equivalents (FTEs) have been hired across the 63 PCNs, improving access to primary care services for British Columbians.**
- **Despite delays caused by the COVID-19 pandemic and challenges in hiring and staff retention, the Province continues to make progress in expanding team-based and urgent primary care and supporting the recruitment of primary care staff, including additional FPs and NPs.**
- **The Primary Care Strategy was developed in response to challenges including increasing numbers of British Columbians without a regular primary care provider, fragmented and varied care across multiple providers, and increasing levels of clinician and provider burnout.**

[1] Ministry of Health, Results Management Office, Primary Care Workforce Report - FY22/23 P10, January 5, 2023

LEGISLATIVE SESSION - ESTIMATES NOTE

CURRENT SITUATION

- As of January 2023, the Ministry of Health has launched 63 PCNs, each at various stages of implementing 4-year service plans (23 in Year 4, 17 in Year 3, 14 in Year 2, and 9 in Year 1).[2] The 63 PCNs under implementation cover communities as per Table 1,Advice/Recommentations

Advice/Recommentations

Government Financial Information

- Of this, approximately $245M supports annual operating costs for 63 PCNs currently in implementation.[3]
  Advice/Recommentations

- The total Community Health Service Areas (CHSAs) covered by PCN communities (in implementation) is 73%, equating to 85% of the provincial population.
- PCN CHSA coverage is highest in Vancouver Island, with approximately 92% of the population and 82% of CHSAs in the region. Vancouver Coastal covers 92% of the population and 78% of the region's CHSAs are covered by PCNs in implementation. Interior covers 64% of the population and 68% of the region's CHSAs currently have a PCN in implementation. Fraser covers 81% of the population and 70% of the region's CHSAs, and Northern covers 69% of the population and 55% of the region's CHSAs.[4]
- As of January 2023, 896 full-time equivalents (FTEs) have been hired into 63 PCNs[5]: 487 FTEs have been hired across 23 PCNs in Year 4 (9 communities); 297 FTEs have been hired across 17 PCNs in Year 3 (11 communities); 85 FTEs have been hired across 14 PCNs in Year 2 (4 communities) and 27 FTEs have been hired across 9 PCNs in Year 1 (3 communities).[6]
- Overall, PCN implementation was delayed relative to the original target of 65 PCNs by April 2022. The COVID-19 pandemic impacted health human resource availability and capacity, which in turn impacted overall implementation progress for PCNs under implementation in 2020 and 2021. Hiring and staff retention, retirements, and new compensation models also contributed to delays.

FINANCIAL IMPLICATIONS

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Government Financial Information		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

- PCNs are supported through a collaborative governance model and a local PCN Steering Committee that reflect and prioritize community primary care needs. Community partners work together to create service plans, outline current primary care gaps and identify resources required to fill the gaps through interdisciplinary providers. Service plans are reviewed and approved by Ministry staff and Executive. Partners then sign a Letter of Intent to receive funding to support implementation.

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[2] Results Management Office FY2022/23 P10 status tracking and CHSA master data as of January 5, 2023.
[3] Ministry of Health, Results Management Office, Primary Care Workforce Report - FY22/23 P10, January 5, 2023
[4] Primary Care Division Results Management Office Primary Care Strategy Report – FY2022/23 P10, as of January 5, 2023.
[5] Gitxsan, Sts'ailes and Dak'elh FNPCCs have not been included in FY 2022/23 P10 Workforce Report, Results Management Office, Primary Care Division.
[6] Ministry of Health, Results Management Office, Primary Care Workforce Report – FY2022/23 (P10), as of January 5, 2023.

- This strategy was developed in response to challenges including increasing numbers of British Columbians without a regular primary care provider, fragmented and varied care across multiple providers, and increasing levels of clinician and provider burnout.

Table 1: PCN Attachment Targets and Annual Funding at Full Implementation (N/A for UPCCs, CHCs, etc.)

Community	PCNs	Annual Operating Funding[7]
Burnaby	4[8]	$10.2M
Comox Valley	1	$6.0M
Fraser Northwest	4	$12.7M
Kootenay Boundary	1	$6.7M
Prince George	1	$4.0M
Richmond	3	$14.0M
Ridge Meadows	2	$6.3M
South Okanagan Similkameen (SOS)[9]	1	$6.8M
Vancouver[10]	6	$34.4M
Total – Year 4 PCNs	***23***	***$101.1M***
Central Interior Rural Division (CIRD)	1	$5.3M
Central Okanagan	3	$10.1M
Chilliwack & Fraser Health Rural	3	$11.7M
Cowichan Valley	1	$6.6M
East Kootenay	1	$7.1M
Mission	1	$3.8M
North Shore (North Vancouver)	3	$11.5M
Oceanside	1	$4.1M
Saanich Peninsula	1	$8.0M
Western Communities	1	$8.9M
White Rock South Surrey (WRSS)	1	$5.1M
Total – Year 3 PCNs	***17***	***$82.2M***
Nanaimo	2	$8.1M
North Peace	1	$1.6M
Northern Interior Rural (NIRD)	7	$3.7M
Victoria	4	$17.7M
Total – Year 2 PCNs	***14***	***$31.1M***
PCNs in Year 1 of Implementation		
Bulkley Valley-Witset	2	$2.8M
Campbell River	1	$5.5M
Surrey-North Delta	6	$21.9M
Total – Year 1 PCNs	***9***	***$30.2M***
Advice/Recommentations		
GRAND TOTAL	**63**	**$244.6M**

LAST UPDATED

The content of this fact sheet is current as of March 1, 2023 as confirmed by Shana Hall obo Shana Ooms, Jennifer Gough and Kelly McQuillen.

APPROVALS

2023 04 14 - Eric Larson obo Martin Wright, Health Sector Information Analysis and Reporting Division
2023 04 17 - Kerri Harrison, Finance and Corporate Services
2023 04 24 - Ted Patterson, Primary Care Division

[7] Annualized funding amounts based on updates as of January 5, 2023.
[8] Includes Burnaby's fourth PCN (Lougheed).
[9] Includes the original service plan approval and the growth plan approved in 2021/22.
[10] Includes the original service plan approval and the growth plan approved in 2020/21.

LEGISLATIVE SESSION - ESTIMATES NOTE

Primary Care Strategy Overview

Topic: The Ministry of Health launched a transformational team-based primary care strategy in 2018/19 to fundamentally change the way primary care is delivered. The intent of the strategy is to increase patient attachment and access to quality, comprehensive, culturally safe, and person-and family-centred primary care services. After ongoing analysis and reviews of progress to date, the province sought to refresh the strategy in fall of 2022 and this work is well underway.

Key Messaging and Recommended Response:

- **The Ministry is making excellent progress in the implementation of our 2018 team-based Primary Care Strategy.**
- **Through this strategy, our government is aiming to provide between 26,400,000 and 29,000,000 patient encounters through longitudinal and episodic primary care each year over the next three years, with an increasing focus on longitudinal care.**
- **A new digitally enabled provincial attachment management system, launching in July 2023, is being developed to facilitate more effective patient attachment.**
- **Several compensation and incentives initiatives are introduced to support the recruitment and retention of family physicians in longitudinal primary care, including the Longitudinal Family Practice Payment Model, New to Practice Incentives Program, and Retention Incentives Program.**
- **A total** Advice/Recommentations **has been committed so far to support team-based models of care through Primary Care Networks (PCNs) under the Strategy, including funding for annual operating costs, capital, start-up costs, and change management costs.**
- **The Ministry aims to have approximately 99 PCNs in implementation by April 2025, covering the majority of BC's communities.**
- **As of January 2023, 1,426 full-time equivalents (FTEs) have been hired out of 2,183.9 approved resources into over 260 clinics and regional hubs, with various roles including Family Physicians, Nurse Practitioners, Registered Nurses, Allied Health Professionals, Indigenous Providers, Clinical Pharmacists, and Program Administrators.**

- **Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.**
- **The Strategy focuses on expanding team-based primary care through various clinical models like Patient Medical Homes, Urgent and Primary Care Centres, Community Health Centres, First Nations Primary Care Clinics, and Nurse Practitioner Primary Care Clinics, all connected through PCNs.**
- **The refreshed Strategy addresses the increasing problem of access to Family Physicians, with measures such as short-term stabilization funding and a new payment model for family doctors.**
- **We look forward to demonstrating continued success in changing the way primary care is delivered in our province.**

CURRENT SITUATION

Primary Care Strategy Implementation as of January 2023

- The primary and community care strategy (the Strategy), now in its fourth year of implementation, is being refreshed based on learning and experience of participating partners over the past several years.
- A key priority in the refreshed Strategy is to provide between 26,400,000 and 29,000,000 patient encounters through longitudinal and episodic primary care in each year over the next three years, with 70% longitudinal care for the first two years and 90% longitudinal care in the third year.
- Another major element of the refreshed primary care strategy will be more effective approach to patient attachment through the development of a digitally enabled provincial attachment management system (rostering) expected to launch in July 2023, which will include:
    - A new and improved solution for patients seeking to be attached to register themselves and their families.
    - A mechanism by which family physicians, nurse practitioners and their clinics will provide patient panel data to the Ministry so that we know who is attached in the province.
    - A clinic and provider registry that will support a better understanding of service capacity in our communities.
- The refreshed strategy will be supported by a number of major compensation and incentives initiatives intended to support recruitment and retention of family physicians in longitudinal primary care. They include:
    - the new Longitudinal Family Practice Payment Model (launched in February 2023),
    - the New to Practice Incentives Program (launched in August 2022) and
    - a Retention Incentives Program (under development).
- The Strategy will continue to include a focus on culturally safe, team-based primary care deployed through a range of different clinical models (family practices, Urgent and Primary Care Centres [UPCCs], Community Health Centres [CHCs], Nurse Practitioner Primary Care Clinics [NPPCCs], First Nations Primary Care Clinics [FNPCCs], and more), all working together as part of local Primary Care Networks (PCNs).

- As of January 2023, the Ministry has committed a total of $562M to support these team-based models of care and the PCNs under the Strategy, including $389M in annual operating costs, $104M in capital, $33M in one-time start up costs and $36M in change management costs.
- Of this, approximately $245M supports annual operating costs for 63 PCNs currently in implementation.[1] The Ministry's target is to have approx. 99 PCNs in implementation by April 2025 covering most of BC's communities.

- As of January 2023, through the various initiatives underway under the strategy 1,426 full-time equivalents (FTEs) have been hired out of 2,183.9 approved resources into over 260 clinics and regional hubs across the province.[2] This includes 272.1 FTE Family Physicians (FPs), 227 FTE Nurse Practitioners (NPs), 428.5 FTE Registered Nurses (RNs), 311.7 FTE Allied Health Professionals (AHPs), 36.5 Indigenous Providers, 44.5 Clinical Pharmacists, and 106.1 Program Administrators.[3]

FINANCIAL IMPLICATIONS

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Government Financial Information		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

- In 2018/19, the Government launched the Primary and Community Care Strategy. The Strategy focused on expanding the use of team-based primary care and establishing it as the new model of care delivery in the province. The goal was to increase patient attachment and access to quality, comprehensive, culturally safe and person and family-centred primary care services.
- The Strategy funded the addition of new FPs, NPs, registered nurses, pharmacists, mental health and addictions workers, physiotherapists, dietitians, and other allied providers, as well as Indigenous supports such as traditional healers and elders delivering patient care. It also supported a range of clinical models including full-service family practices/Patient Medical Homes (PMHs), UPCCs, CHCs, FNPCCs and NPPCCs. Both existing and new clinical models have been linked together in PCNs throughout the province.
  - PMHs are family practices that provide longitudinal primary care to patients across the province. PMHs are the foundation of care delivery within PCNs—the cornerstone of an integrated system of primary and community care.
  - UPCCs provide flexibility to meet both the urgent unplanned and ongoing planned primary care needs of people in communities across the province. UPCCs fulfill service gaps and are full-service team-based care facilities which provide urgent, non-emergency primary care to people who need medical attention within 12-24 hours. UPCCs also provide temporary and/or ongoing attachment to patients who do not currently have a regular care provider, and then work to attach patients elsewhere as capacity opens within a broader PCN. UPCCs offer extended hours and increased attachment for under-served populations.
  - CHCs include health authority owned and operated, or community governed/informed, and/or Ministry funded clinics. Ministry-funded CHCs are multi-sectoral health and social service not-for-profits providing primary health care. CHCs also prioritize the attachment of vulnerable and under-served communities, and are a key resource in helping to address social determinants of health.

[1] Ministry of Health, Results Management Office, Primary Care Workforce Report - FY22/23 P10, January 5, 2023
[2] Ministry of Health, Results Management Office, Primary Care Workforce Report - FY22/23 P10, January 5, 2023
[3] Ministry of Health, Results Management Office, Primary Care Workforce Report - FY22/23 P10, January 5, 2023

  - FNPCCs are First Nations-led initiatives developed in partnership with the Ministry and First Nations Health Authority (FNHA). They deliver team-based culturally safe primary health care and improve coordinated access to social services for First Nations and Indigenous peoples living in BC. FNPCCs combine both Western and Indigenous approaches to health and wellness, and incorporate and promote First Nations' knowledge, beliefs, values, practices, and models of health and healing, recognizing that these may be reflected uniquely in the different Nations and communities across BC.
  - NPPCCs are a unique model developed by NPs. The model sees NPs working within a collaborative, team-based environment, both within their practice and as part of the local PCN. NPPCCs are an innovative solution to support communities who may have difficulty accessing a regular primary care provider.
- While real progress had been made in increasing access to team-based primary care services, access to FPs has been increasingly problematic. Underpinning this was the inadequate numbers of new graduates choosing full-service family practice combined with an increasing number of full-service family physicians choosing to retire. The result was an increasing number of BC residents having difficulty attaching to a primary care provider (i.e., FP or NP) and in some instances even accessing primary care in a timely way.
- In 2022, in collaboration with health care partners, the Ministry took steps to refocus the Strategy to better address issues that were affecting the number of FPs in family practice, the cornerstone of longitudinal primary care, or limiting access to urgent and episodic care provided by UPCCs, walk-in clinics, community pharmacies and virtual care services.
- In addition, in August 2022, the Ministry and Doctors of BC announced $118M in short-term stabilization funding to family doctors, to help them ensure their patients continued to receive access to primary care services, while a new payment model was developed (Family Practice Services Committee [FPSC] provided $43M of this funding).
- Mandate letter (Dec 2022) asked Minister to "increase the number of British Columbians with access to a doctor by recruiting and supporting more family doctors with the new payment model for family physicians, building new First Nations primary care centres, and building on other methods of delivering health care at the community level in partnership with medical professionals."

LAST UPDATED

The content of this fact sheet is current as of March 6, 2023 as confirmed by Jennifer Gough and Kelly McQuillen.

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division
2023 04 17 - Kerri Harrison obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Primary Care Strategy Recruitment

Topic: Overview of the status of recruitment across all primary care initiatives funded through the provincial primary care strategy, inclusive of resources provided through Primary Care Networks (PCNs), Urgent and Primary Care Centres (UPCCs), Community Health Centres (CHCs), First Nations Primary Health Care Centres (FNPCCs), and Nurse Practitioner Primary Care Clinics (NPPCCs).

Key Messaging and Recommended Response:

- **Successful recruitment is critical to transition to a team-based care system in BC, improving access to care, and enhancing patient outcomes.**
- **That is why we are recruiting healthcare professionals, including physicians, nurse practitioners, pharmacists, and others, to ensure patients receive the right care, in the right place, and at the right time.**
- **As of January 2023, 1,426.4 of 2,183.9 approved full-time equivalent (FTE) resources have been recruited into approximately 260 clinics and regional hubs across all primary care initiatives to support the strategy.**
- **Primary Care Networks (PCNs) are implemented on four-year timelines. As more PCNs and the clinical practices within them reach Year 4 of implementation, we expect to see budgeted staffing levels reach 100% and won't stop recruiting until they do.**
- **So far, most PCNs are hitting their staffing targets. For those in need of assistance in hiring more staff, we have introduced several reforms to increase staffing and retention in the primary care system.**
- **We are expanding post-secondary education seats and financial support for nurses, allied healthcare professionals, and physicians through our Health Care Human Resources Strategy.**
- **In addition, this past November, we implemented major reforms to increase the number of IMGs serving in BC, specifically to work in PCNs:**
    - **We tripled the number of seats in the Practice Ready Assessment-BC program 32 seats to 96 seats by March 2024. Half of all graduates will practice in priority primary care networks after receiving licensure; and**
    - **Working with the College of Physicians and Surgeons of BC to prepare bylaw changes to allow doctors trained in the U.S. for three years**

to practice medicine in community settings, such as urgent and primary care centres, community clinics, and family practices.

CURRENT SITUATION

- As of January 2023, 1,426.4 of 2,183.9 approved full time equivalent (FTE) resources[1] have been recruited into approximately 260 clinics and regional hubs across all primary care initiatives to support team-based care:
  - 486.9 FTEs hired across 23 PCNs in Year 4 of implementation (covering 9 communities)
  - 297.1 FTEs hired across 17 PCNs in Year 3 of implementation (covering 11 communities)
  - 85.0 FTEs hired across 14 PCNs in Year 2 of implementation (covering 4 communities)
  - 27.0 FTEs hired across 9 PCNs in Year 1 of implementation (covering 3 communities)
  - 410.1 FTEs hired in 30 UPCCs
  - 29.4 FTEs hired in 3 NPPCCs
  - 69.2 FTEs hired in 6 CHCs
  - 21.7 FTEs hired in 2 FNPCCs[2]
- By profession, recruitment to date includes:
  - 272.1 FTEs of Family Physicians (of 371 FTEs approved)
  - 227.0 FTEs of Nurse Practitioners (of 321.6 FTEs approved)
  - 428.5 FTEs of Nursing Resources (of 662.4 FTEs approved)
  - 311.7 FTEs of Allied Health Professionals (of 579.7 FTEs approved)
  - 44.5 FTEs of Clinical Pharmacists (of 60.5 FTEs approved)
  - 106.1 of 127.6 FTEs of Administrative Staff, including PCN Managers, Admin staff and other
  - 36.5 FTEs of Indigenous Health Resources, including Elders, Traditional Healers, and Health Coordinators (of 61.2 FTEs approved)[3]

FINANCIAL IMPLICATIONS

Budget 2023 includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over three years for the refreshed Primary Care Strategy that provides a new compensation model for family practitioners, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Government Financial Information		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

As of January 2023:

- 23 PCNs covering 9 communities are in Year 4 of implementation:
  - Fraser: Burnaby (4); Fraser Northwest (4); Ridge Meadows (2)
  - Interior: Kootenay Boundary (1); South Okanagan Similkameen (1)
  - Northern: Prince George (1)
  - Vancouver Coastal: Richmond (3); Vancouver (6)
  - Island: Comox Valley (1)

[1] Ministry of Health, RMO Primary Workforce Report, FY2022/23 Period 10, January 5, 2023.
[2] Gitxsan, Sts'ailes and Dak'elh FNPCCs have not been included in FY 2022/23 P10 Workforce Report, Results Management Office, Primary Care Division.
[3] Includes Sts'ailes FNPCC where the site is not open but approval has been given for hiring to commence

- 17 PCNs covering 11 communities are in Year 3 of implementation:
  - Fraser: Chilliwack and Fraser Health Rural (3); Mission (1); White Rock/ South Surrey (1)
  - Interior: Central Interior Rural (1); Central Okanagan (3); East Kootenay (1)
  - Vancouver Coastal: North Shore (3)
  - Island: Cowichan Valley (1); Oceanside (1); Saanich Peninsula (1); Western Communities (1)
- 14 PCNs covering 4 communities are in Year 2 of implementation:
  - Northern: North Peace (1); Northern Interior Rural (7)
  - Island: Nanaimo (2); Victoria (4)
- 9 PCNs covering 3 communities are in Year 1 of implementation:
  - Fraser: Surrey North Delta (6)
  - Northern: Bulkley Valley-Witset (2)
  - Island: Campbell River (1)
- There are 30 UPCCs now operating across the province:
  - Fraser: North Surrey/Whalley; Edmonds; Ridge Meadows; Surrey Newton; Abbotsford; Port Moody; Burnaby Metrotown
  - Interior: Kamloops; Kelowna; Vernon; Castlegar; West Kelowna; Penticton; Cranbrook; Ashcroft
  - Northern: Quesnel; Prince George
  - Vancouver Coastal: City Centre; North Vancouver; REACH; Northeast; Richmond; Southeast
  - Island: Westshore; Nanaimo; James Bay; North Quadra; Downtown Victoria; Esquimalt; Gorge Road
- Other Primary Care Initiatives:
  - Fraser: Fraser Northwest (Umbrella Multicultural Health Cooperative CHC); Abbotsford (early draw allied health); Langley (early draw allied health); Surrey (Axis NPPCC); Roots (CHC); Sts'ailes Community Care Centre (FNPCC)
  - Vancouver Coastal: Vancouver (RISE CHC; Lu'ma Medical Centre [FNPCC]); Powell River (Early Draw NP); Pemberton (Early Draw NP); Sea to Sky (Early Draw NP)
  - Interior: Williams Lake First Nations Wellness Centre (FNPCC)
  - Vancouver Island: Nanaimo (Nexus NPPCC); Victoria (Health Care on Yates NPPCC); Campbell River (Early Draw NPs); Island Sexual Health (CHC), Westshore Pacific Centre (CHC) and Luther Court Society (CHC)
  - Northern: Dawson Creek, South Peace PCN (Early draw NPs); Dak'elh First Nations Primary Health Care Centre (Early draw FNPCC) and Gitxsan & Wet'suwet'en Primary Care Centre Early draw FNPCC)

LAST UPDATED

The content of this fact sheet is current as of March 2, 2023, as confirmed by Shana Hall obo Shana Ooms, Jennifer Gough and Kelly McQuillen.

APPROVALS

2023 03 10 – Ted Patterson, Primary Care Division
2023 04 06 - Kerri Harrison obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Short Term Stabilization Initiatives

Topic: Since April 2022, the Ministry of Health has been providing short term stabilization funding to selected longitudinal and episodic primary care practices. The intent of the stabilization funding is to support critical primary care services while the Ministry collaborates with Doctors of BC on longer term solutions to support access to primary care across the province.

Key Messaging and Recommended Response:

- **The BC government made available $118 million in stabilization funding to support family practice clinics prior to implementing a new payment model, (Family Practice Services Committee (FPSC) provided $43M of this funding). Actual stabilization funding allocated was $110.9M:**

Government Financial Information

- **The Ministry and Doctors of BC collaborated closely in the development and consultation process for the new payment model, ensuring that physician perspectives were taken into account.**
- **The short-term funding was designed to provide financial stability for family practice clinics during the four-month transition period between the old and new payment systems.**
- **The interim stabilization funding was a testament to the BC government's commitment to support family physicians and maintain the quality of healthcare in the province during this transition.**
- **The new payment model for longitudinal family physicians was ultimately introduced in October 2022, following extensive consultation and planning, reflecting the BC government's dedication to modernizing and improving healthcare compensation systems.**

CURRENT SITUATION

- In February 2022, the Western Communities and Saanich Peninsula Primary Care Network (PCN) Steering Committee "Walk-in clinic (WIC) Task Group" submitted a proposal requesting temporary stabilization funds to support South Island WICs "*at risk of closure*." Reasons cited for closure included inability to recruit family physicians (FPs), in part due to available remuneration and insufficient FP overhead.
- On April 8, 2022, the Ministry announced approximately $3.46 million in stabilization funds for a nine-month period of April 1 - December 31, 2022, to support five WICs in the South Island.

- In November 2022, the Ministry approved additional funding of $900,703 to the five WICs to ensure stabilization through to March 2023.
    - The five south Vancouver Island WICs were: the Esquimalt Medical Clinic; Shoreline Medical clinics in Brentwood Bay and Sidney; West Coast Family Medical Clinic in Sooke; and West Saanich Medical Clinic. Specific supports at these locations include:
        - funding for approx. 10.3 full-time-equivalent (FTE) FP contracts across the five WICs for nine months, through December 31, 2022;
        - funding for approx. 6.8 FTE registered nurse and allied health resources for the South PCNs, which supported the five walk-in clinics for nine months, and then were redeployed as permanent resources within the PCNs;
        - overhead funding in support of the FTEs; and
        - funding for project management for the South Island PCN Steering Committee to support this work in the months ahead.

Advice/Recommentations; Government Financial Information

- In August of 2022, the Ministry announced up to $118 million in stabilization funding for family practice clinics in the province. The Ministry and Doctors of BC were, at the time, in consultation regarding a new payment model for longitudinal family physicians, which was announced in October 2022. The short-term funding was to be for four months, from October 1, 2022, to January 31, 2023, and function as an interim solution to the new compensation model, which was announced in October 2022.
    - This funding was ultimately provided in the amount of $110.85M[2] broken down as follows (addition error due to rounding):

Government Financial Information

    - Family Practice Services Committee (FPSC) provided $43M to the funding.
    - A requirement of accessing these stabilization funds was that clinics were required to fill out a survey about their clinics through Doctors of BC. This information will be used as baseline information by the Ministry to populate a new clinic and provider registry for the province that will help us better understand primary care service infrastructure and capacity in our communities.
- In February 2023 the Ministry provided short-term bridge funding for Park & Tilford Medical Clinic ($31,535.00) in North Vancouver and Sterling Clinic ($38,043.38) in Vernon for a three-month period from February 1, 2023 to April 30, 2023. This temporary stabilization fund allows time for the Ministry and Doctors of BC to develop lasting solutions for walk-in clinics.

Government Financial Information

Advice/Recommentations; Government Financial Information

[2] As per HWSBS, Compensation Policy & Programs March 13, 2023

- With the launch of the new Longitudinal Family Practice Payment Model in February 2023, the Ministry is intending to move away from any further short-term stabilization supports; however, it is currently in discussions with Doctors of BC regarding support that may be required for clinics as they transition toward the new payment model.

FINANCIAL IMPLICATIONS

The BC government allocated a total of 130.72M in short term stabilization initiatives in 2022/23, as follows:

- Stabilization funding for five South Island PCN walk-in clinics – $4.4 million

Advice/Recommentations; Government Financial Information

- Short-term stabilization funding for family doctors, for the period October 2022 through January 2023 - $118M

Advice/Recommentations; Government Financial Information

KEY BACKGROUND

- The Canadian Community Health Survey (CCHS) data on attachment from 2003 to 2021 suggests an overall downward trend over time in the number of people (aged 12+) identifying as having a regular primary care provider in BC, from 89.4% in 2003 to 83.0% in 2021.[3] Stated differently, the number of people identifying as not attached in BC has increased from 10.6% in 2003 to 17.0% in 2021. Of note, between 2020 and 2021, there was a 2.1% increase in the number of people identifying as attached, similar to rates seen in 2016.
- Only 25.8% of British Columbians report being able to access same or next day appointments with their primary care providers.[4]
- Recently, WICs (which may solely provide episodic walk-in services or may be a hybrid of longitudinal and episodic services) have also been raising concerns about the costs of operating their clinics and their inability to recruit physicians on a fee-for-service basis.
- Historically, many WICs were seen to be addressing only the easiest of cases, leaving complex patients for other parts of the system. However, in some communities with significant lack of attachment, the patients presenting at walk-ins were increasingly complex, meaning fee-for-service did not adequately remunerate physicians for their time with these patients (a commonly identified issue for all fee-for-service physicians treating complex patients).
- Additionally, these patients attended the WICs regularly, meaning the clinic was essentially responsible for providing longitudinal care according to College practice standards.
- WICs are not able to access FPSC incentives for complex patients, nor do they have access to PCN funding and resources which are primarily intended to support team-based longitudinal care.
- With these WICs now expressing concerns about sustainability of their operations, full-service family practices were also very concerned that their practices could not simply absorb patients no longer able to access walk-in services if that clinic closed.
- FPs working in longitudinal care expressed a desire to be compensated in a way that addressed the disparities with other practice options, and they wanted their clinic infrastructure to be recognized and funded as an essential part of the health care system.

LAST UPDATED

The content of this fact sheet is current as of March 13, 2023, as reviewed by Jennifer Gough, Kelly McQuillen.

[3] Stats Canada. Canadian Community Health Survey. 2021. Table 13-10-0096-16 Has a regular healthcare provider, by age group. Last accessed Feb 22, 2023.

[4] Statistics Canada, Canadian Community Health Survey. 2021. Title: Proportion of people reporting they can have a same day/next day appointment from their regular health care provider's office for a minor health problem, by province, population aged 12 and older who have a regular health care provider, 2021. Unpublished data provided by request on Sept 3, 2022 via email.

LEGISLATIVE SESSION – ESTIMATES NOTE

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division
2023 03 30 - Eric Larson obo Martin Wright, Health Sector Information Analysis and Reporting Division
2023 04 13 - Kerri Harrison obo Rob Byers, Finance and Corporate Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Urgent and Primary Care Centres

Topic: Urgent and Primary Care Centres (UPCCs) were developed to improve access to same day urgent, non-emergency primary care, and increase existing primary care capacity and reducing pressures on emergency departments and enable new patient attachment.

Key Messaging and Recommended Response:

- **Everyone in BC deserves access to quality healthcare when and where they need it.**
- **UPCCs are playing an essential role in our primary care strategy.**
- **They are part of our transformational primary care strategy that includes Community Health Centres, First Nations Primary Care Clinics, and Nurse Practitioner Clinics.**
- **UPCCs also provide an attractive practice option for physicians who may not want to work in private practice and prefer working in a team-based model with more predictable hours.**
- **When many family practices opted to provide virtual care at the beginning of the pandemic, UPCCs remained open and provided extraordinary in-person care to patients.**
- **Since 2018, UPCCs have received more than 1.6 million visits.**
- **We have 30 UPCCs open, and we aim to have 40 by the end of this year (2023/24) and 50 by 2024/25.**
- **In addition to providing urgent care, UPCCs also directly attach patients to a primary care provider and can help them find a primary care provider in their community.**
- **UPCCs have four-year implementation plans to hire a full complement of staff and deliver all planned services.**
- **As staffing levels rise to 100% of allocated full-time-equivalent healthcare providers, more UPCCs will increase their operating hours and expand their services.**
- **As of January 10, 2023, UPCCs have attached 25,881 patients.**

LEGISLATIVE SESSION – ESTIMATES NOTE

- **Whether UPCCs and Primary Care Centres, Community Health Centres, or better empowering family doctors to run their own practices – our government's investments in primary care have made a career in family medicine attractive no matter what clinical setting a physician chooses to practice in.**

CURRENT SITUATION

- As part of the province's primary care strategy, the Ministry of Health is committed to having a total of 50 UPCCs operating across the province in 2025.
- As of January 2023, there are 30 UPCCs operating in the province. The target for operational UPCCs in BC is 50 by 2024/25. Currently, 19 additional UPCCs are planned including: 7 for 2023/24, and an additional 12 for 2024/25.
- As of January 2023, UPCCs have collectively provided 1,633,353 patient visits and attached 25,881 patients.[1,2]
- As of January 2023, UPCCs have hired 410.1 full-time equivalents (FTEs) 75% of their approved 549.3, including 90 FTE Family Physicians (FPs) (or 71.8% of approved FP FTEs), 45.3 FTE Nurse Practitioners (or 62.6% of approved FTEs), 184.9 FTE Nursing (or 86% of approved FTEs), 76.1 FTE allied health professionals (or 63% of approved FTEs), and 6.0 FTE Clinical Pharmacists (or 87% of approved FTEs).[3]

FINANCIAL IMPLICATIONS

- As of January 2023, the estimated annual operating costs for the 30 UPCCs in operation are $110M.
- Across all 30 UPCCs, 25 have required capital funding, consisting of $56.8M from the Ministry, $5.5M from health authority internal sources, $10.9M from regional hospital districts, and $2.5M from landlords.
- *Budget 2023* includes targeted funding from previous years' budgets to continue advancing the Primary Care Strategy as well as nearly $1.1 billion over 3 years for the refreshed Primary Care Strategy that provides a new compensation model for FPs, incentives to attract recent graduates into family practice, and to retain those approaching retirement.

($ millions)	2023/24	2024/25	2025/26	3 Year Total
Budgets 2018-2022	$280.3	Government Financial Information		
Budget 2023*	$399.1			
Grand Total	**$679.4**	Government Financial Information		**$1,941.9**

*Includes allocations funded from the Contingencies Vote.

KEY BACKGROUND

- UPCCs are a flexible resource designed to meet the episodic and longitudinal primary care needs of people in select communities across the province, providing urgent, episodic, and non-emergency primary care to people who need medical attention within 12-24 hours and full-service, comprehensive longitudinal primary care to patients attached to the UPCC.
- When possible, UPCCs use alternate compensation models rather than the traditional fee-for-service model to better support team-based care.
- UPCC locations were selected based on several factors, including a review of data such as emergency department utilization, patient access, and attachment rates.
- UPCCs reflect different business models. While mainly health authority owned and operated, some early sites are operated by local FP clinics together with health authority partners. All are planned in partnership with local Divisions of Family Practice.

[1] UPCC self reported volume and visits data P10 FY2022/23, Results Management Office. As of January 5, 2023.
[2] Primary Care Quality, Primary Care Division. UPCC Attachment Summary (extracted from UPCC period reports). As of January 5, 2023.
[3] Results Management Office, Primary Care Division. Primary Care Workforce Report P10 FY2022/23 P10. As of January 5, 2023.

- The first 11 UPCCs were developed under initial policy direction focused primarily on non-emergency, urgent situations that can be treated by a primary care provider within 12-24 hours, access for unattached patients, and extended hours.[4] Starting in 2019, the revised UPCC policy included on-site attachment and a greater emphasis on longitudinal care.
- All UPCCs include some mental health and substance use (MHSU) access and/or services and can coordinate rapid access to MHSU crisis intervention services. Some have more extensive MHSU services than others (e.g., Vernon UPCC focuses on providing specialized services and support to those experiencing MHSU challenges and Nanaimo provides timely access for patients looking for Opioid Agonist Therapy).
- As of January 2023, by UPCC initiative, visits and attachments are as follows:[5,6]

Health Authority	UPCC	Date Opened[7]	Number of Patient Visits	Number of Attachments
Fraser	Surrey North	November 8, 2018	113,795	2,109
	Burnaby Edmonds	September 23, 2019	54,368	1,268
	Ridge Meadows	October 1, 2019	44,241	1,867
	Surrey Newton	May 25, 2020	43,816	1,623
	Abbotsford	April 17, 2020	39,112	1,229
	Port Moody	February 22, 2021	24,380	695
	Metrotown	November 1, 2022	4,665	24
Interior	Kamloops	June 12, 2018	118,357	1,330
	Kelowna	December 30, 2019	116,581	0
	Vernon	October 1, 2019	67,709	1,045
	Castlegar	April 6, 2020	13,666	2
	West Kelowna	October 5, 2020	39,775	857
	Penticton	March 31, 2021	33,433	277
	Cranbrook	December 8, 2021	18,825	0
	Ashcroft	September 27, 2022	923	0
Northern	Quesnel	October 31, 2018	28,698	1
	Prince George	June 5, 2019	121,038	225
Vancouver Coastal	Vancouver City Centre	November 26, 2018	130,898	2,969
	North Shore	November 4, 2019	90,339	0
	REACH (East Vancouver)	November 4, 2019	56,469	0
	Vancouver Northeast	February 16, 2021	39,647	10
	Richmond	April 1, 2021	38,014	0
	Vancouver Southeast	March 29, 2022	17,633	1,943
Vancouver Island	Westshore	November 5, 2018	101,912	1,973
	Nanaimo	June 3, 2019	108,715	2,184
	James Bay	April 28, 2020	52,463	2,253
	North Quadra	November 30, 2020	34,611	468
	Esquimalt	June 14, 2021	21,495	282
	Victoria (Downtown)	July 19, 2021	54,978	996
	Gorge Road	September 19, 2022	2,797	251

LAST UPDATED

The content of this fact sheet is current as of March 3, 2023 as confirmed by Shana Hall obo Shana Ooms, Kelly McQuillen and Jennifer Gough

APPROVALS

2023 03 10 - Ted Patterson, Primary Care Division

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[4] "0 attached patients" does not yet reflect facilitation to the PCN.
[5] Results Management Office, Primary Care Division. UPCC Patient Visits and Services Data Tracker; self reported data submitted by the UPCCs; not independently verified with zero fee-based codes. As of January 5, 2023. Excludes facilitated attachment to a PCN.
[6] Primary Care Quality, Primary Care Division. UPCC Attachment Summary (extracted from UPCC period reports). As of January 5, 2023.
[7] Results Management Office, Primary Care Division. UPCC Status Tracker. As of February 15, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

Access and Admission to Long-Term Care

Topic:

- On July 15, 2019, the policy regarding access to long-term care (LTC) in the Home and Community Care (HCC) Policy Manual was revised to provide greater choice for individuals and their families through a more client-centred, consistent, transparent, and clear LTC access process.
- The LTC Access Policy complies with Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFAA), which came into force November 4, 2019.
- Both the policy and the legislation address recommendations made in the Ombudsperson's 2012 seniors' care report and promote a more client-centred approach to how seniors enter LTC homes.
- The new LTC Access Policy also addresses recommendations made by the Seniors Advocate in her 2015 housing report and enhances the transparency, consistency, and clarity of the access process.

Key Messaging and Recommended Response:

- **In 2019, following requests from many seniors, and recommendations from the Ombudsperson and the Seniors Advocate, we changed the policy regarding access to long-term care to allow for more choice for people requiring care.**
- **The Ministry and Health Authorities meet monthly to review the current situation and address any issues that may arise.**
- **While the access policy was affected by provincial health orders during the COVID-19 pandemic, overall we are seeing that people are being admitted to long-term care more quickly from acute care. There is an increase in waits for admission to long-term care from the community directly.**

CURRENT SITUATION

LTC Access Policy

- The Ministry of Health and health authority leads meet on a monthly basis and continue to review the impact of the policy changes and address any issues that arise.
- The Ministry is monitoring the impact of the revised LTC Access Policy over time through collection of data and information from health authorities. At Q3 2022/23[1]:
  - In BC, clients admitted to LTC from acute care waited, on average, 47 days, if their wait started in hospital, and 138 days, if their wait started in community prior to acute care admission.
  - Clients admitted to LTC directly from community waited, on average, 4.5 months (139 days).
  - When looking at both admissions from community and from acute care in Q3, 36% of clients were admitted directly to a Preferred Care Home (PCH). Broken down, 28% of LTC admissions from acute care were to a PCH and 44% of LTC admissions from community were to a PCH. At the provincial level, admissions directly to a PCH have decreased since the policy was implemented, from 42% in Q3 2019/20 to an average of 37% (ranging between 34-38%) over the last four quarters (as of Q3 2022/23).
  - Clients admitted to an Interim Care Home (ICH) and transferred to a PCH in Q3 waited an average of 7.5 months (227 days) for transfer to a PCH.

[1] Ministry of Health. Long-Term Care Access Monitoring Indicators Summary Report (2022/23 Q3).

  - Initial concerns that the average provincial length of stay (LOS) of alternative level of care (ALC) patients in acute care would be negatively impacted by the policy change have not materialized (based on the most recent hospital data for Q2 2022/23).
    - The Q2 2022/23 provincial proportion of ALC patients waiting for LTC was 20% (1,038 clients).
    - Although the average LOS increased slightly during the implementation phase of the new LTC access policy (43-46 days in 2019/20), the average LOS has decreased since then and remained relatively consistent over the last ten quarters (average of 32 days, ranging between 27-37 days).
- It should be noted data from 2020/21 and 2021/22 are not directly comparable to 2019/20 data due to the impact of COVID-19 and the policy adjustments, restrictions, and suspensions implemented to mitigate the risk of introduction and transmission of COVID-19 in LTC homes and to support acute care capacity. However the following provides some observed trends.[2]
  - Average quarterly wait times for admissions directly from the community have increased since 2019/20. (79-81 days until Q1 2020/21, compared to 84-139 days from Q2 2020/21 onwards.)
  - Average quarterly wait times for admissions directly from acute care decreased from Q3 2019/20 (38 days) to Q1 2022/23 (25 days), but increased in the last two quarters (32-47 days).
  - Average quarterly wait times for transfers from an ICH to a PCH have increased since 2019/20. (114-162 days until Q1 2020/21, compared to 159-261 days from Q2 2020/21 onwards.)
  - Average quarterly LOS for ALC patients waiting for LTC has decreased since 2019/20. (43-46 days in 2019/20, compared to 27-37 days from 2020/21 onwards.).

Part 3 of HCCCFAA

- In the fall of 2019, the Ministry delivered sessions across the Province to provide information to and answer questions from health authority staff and facility operators about the legislative changes.
- Health authorities and facility operators are able to access resources created by the Ministry such as the Practice Guidelines for Seeking Consent to Care Facility Admission and an e-learning course.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

LTC Access Policy

- HCC Policy Manual, Chapter 2.D, Client Access, Assessments, and Chapter 6, LTC Services, provide the regional health authorities with direction for planning and delivering publicly subsidized LTC services.
- The LTC Access Policy ensures compliance with Part 3 of the HCCCFAA, by removing any elements in the previous admission criteria that could be construed as coercive, such as the requirement that a client accept the first appropriate bed in order to be eligible for LTC.
- The LTC Access Policy meets recommendations from the Ombudsperson to be more client-centred, consistent, transparent, and clear, including:
  - ensuring clients and/or their substitute decision makers receive comprehensive, clear, and consistent information about options for care homes that meet the clients' needs, the admission process to an LTC home, and the process for transfers from an ICH to a PCH;
  - increasing the number of PCHs that a client can choose, up to 3, where possible;
  - allowing more time to accept or decline a move into an ICH;
  - informing clients who are waiting for an offer of an ICH or a PCH of their options to wait at home with publicly funded and/or private-pay home support, or choose to reside in a private-pay care home;
  - allowing a client to maintain their position on the waitlist for a PCH whether they decline an offer of an ICH or move into an ICH (one wait list approach); and
  - for those clients in hospital waitlisted for LTC services and unable to return home prior to being admitted to a care home:

[2] Ibid

- the expectation is that they will agree to move to an appropriate ICH while waiting for one of their PCHs (or they may choose to move to a private-pay care home); and
- if they decline an ICH/PCH offer and elect to remain in hospital, then client charges will be based on provincial acute care policy (updated in December 2019 to align with LTC Access Policy changes).

Part 3 of HCCCFAA

- Part 3 of the HCCCFAA legally requires consent is obtained for an adult's admission into a care facility, including LTC homes and licensed mental health and substance use facilities.
- This consent is given by the adult to be admitted, unless they have been determined to be incapable of giving or refusing consent to care facility admission, through an assessment conducted according to the requirements of the HCCCFAA and Health Care Consent Regulation.
- An incapability assessment can be conducted by a registered nurse, registered psychiatric nurse, nurse practitioner, psychologist, occupational therapist, social worker, or a medical practitioner.
- If the adult is determined to be incapable of giving or refusing consent, consent must be obtained from a substitute, according to the ranked list set out in legislation. In the event there is no appropriate substitute available, the Public Guardian and Trustee can make the care facility decision on behalf of an incapable adult.
- If a person is found incapable of giving or refusing consent, they have the right to a second assessment. Second assessments must be conducted by a medical practitioner or nurse practitioner if the first assessment was not done by one of these professions.

LAST UPDATED

The content of this fact sheet is current as of March 17, 2023, as confirmed by Danielle Prpich.

APPROVALS

2023 03 01 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 04 24 - Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Assisted Living – Seniors

Topic: Under the authority of the *Community Care and Assisted Living Act* (CCALA) and the Assisted Living Regulation (Regulation), the Assisted Living Registry (Registry) registers assisted living residences, conducts site inspections, and responds to complaints.

Key Messaging and Recommended Response:

- **Our government believes that all people in BC should feel empowered to lead a comfortable lifestyle, especially seniors.**
- **The Province is supporting seniors through Assisted Living (AL), which enables seniors to live safely in a semi-independent environment.**
- **AL is congregate housing that provides one or more Assisted Living services (i.e., assistance with activities of daily living, assistance with medication management, assistance with safekeeping money and personal property, assistance with managing therapeutic diets, assistance with behaviour management, and psychosocial supports) and five hospitality services (meals, housekeeping, laundry, recreation, emergency response system).**
- **The Assisted Living Registry (Registry) registers Assisted Living residences and responds to complaints or other information that indicates residences are being operated in a way that does not ensure the health and safety of the residents, or that an unregistered Assisted Living residence is being operated.**
- **Government is supporting the (Registry) with additional staff and flexible working options to improve the accessibility and quality of services for seniors provincewide.**
- **And to ensure there are mechanisms for accountability so that seniors can access the quality services they deserve.**

CURRENT SITUATION

- The Registry continues to administer its operational requirements under the CCALA.
- The Registry is experiencing ongoing staffing and database challenges and has been struggling to respond to and address registration applications and public complaints in a timely manner.
- The Registry has been unable to implement proactive ongoing regulatory education and operator compliance inspections due to staffing vacancies.
- The Registry has approval for additional staff in the new fiscal year. It is anticipated that this increase, as well as new flexible working options, will assist the Registry in recruiting staff and in carrying out the legislative duties under the CCALA.

- Renewal of each registration is an annual requirement under CCALA and registrations expire annually on March 31.
- The renewal process includes a review of each residence to confirm or update the number of registered units, update any changes to business operations and staffing, as well as confirmation of the services being offered to residents.
- An initial registration process typically takes between 3 – 6 months for each new applicant to complete. This includes time for the applicant to complete all the required components (such as municipal approvals and business licensing) as well as for the applicant to submit the required policies to the Registry. The Registry then reviews all of documents and policies to ensure that they meet regulatory requirements. Once this process is completed a registration can then be issued.

Ongoing work carried out by the Registry includes:

New Registrations, De-registrations, and Renewals April 1, 2022, and January 31, 2023

- 14 applications to open Seniors residences were received:
  - 8 have been approved, and were for a change in ownership,
  - 5 are still in process, and
  - 1 was refused.
- No existing registrations were cancelled.
- 204 Seniors' registration residences were renewed, and 3 residences were de-registered as a result of operators changing their business model or choosing to stop operating.

Incident Reports April 1, 2022 and January 31, 2023

- 4307 incident reports were received, reviewed and closed.
- The Regulation requires incident reports to be submitted by the operator within 24 hours of an incident occurrence. Operators must report on specific incident types as required by the Regulation such as missing/wandering residents, falls and disease outbreak.
- Registry staff review and follow up with the operator on incidents they report. Some incident reports require multiple follow ups and further assessment for compliance with the legislation and to ensure the operator is protecting the health and safety of their residents.

Site Inspections April 1, 2022, and January 31, 2023

- 45 Seniors residence site inspections were conducted by the Registry.
- Site inspections included complaint follow up, new registrations and education.

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

- Assisted Living (AL) is congregate housing that provides 1 or more AL services (i.e., assistance with activities of daily living, assistance with medication management, assistance with safekeeping money and personal property, assistance with managing therapeutic diets, assistance with behaviour management, and psychosocial supports) and 5 hospitality services (meals, housekeeping, laundry, recreation, emergency response system).
- AL residences for seniors' support adults who require support but can make decisions on their own behalf that are necessary to live safely in a semi-independent environment.
- The Registry registers AL residences and responds to complaints or other information that indicates residences are being operated in a way that does not ensure the health and safety of the residents, or that an unregistered AL residence is being operated. Anyone with a concern can make a complaint to the Registry. Registry staff conduct investigations that are remedial in nature.
- Residences which meet the definition of AL are required to be registered with the provincial Registry, regardless of whether they are publicly subsidized or private pay.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of February 6, 2023, as confirmed by Sue Bedford.

APPROVALS

2023 02 06 - Sue Bedford Seniors' Services Division
2023 02 12 - Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Better at Home Program

Topic: Better at Home (BH) is a community-based program funded by the provincial government and managed by the United Way of BC (UWBC) that provides seniors with access to simple, non-medical home support services (light housekeeping, light yard work, snow shoveling, grocery shopping, minor home repairs, transportation to appointments and friendly visiting) to help them stay independent in their own homes and connected to their communities.

Key Messaging and Recommended Response:

Advice/Recommentations

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- **The program provides seniors with access to simple, non-medical home support services (light housekeeping, light yard work, snow shoveling, grocery shopping, minor home repairs, transportation to appointments and friendly visiting) to help them stay independent in their own homes and connected to their communities.**
- **Program sites are selected based on criteria (i.e., proportion of seniors, number of seniors likely to require Better at Home services) and guidance from seniors' organizations and local and regional experts.**
- **There are currently 91 programs in BC, including:**
    - **15 programs in the Fraser Health Region;**
    - **26 in the Interior Health Region, including three news ones;**
    - **15 in the Northern Health Region, including two new ones;**
    - **16 in the Vancouver Coastal Health Region; and**
    - **19 in the Island Health Region.**
- **In addition, there are six new programs that will be added by the end of 2023.**
- **Local circumstances determine sliding-scale fee structure and services available. Eligible seniors with low-income receive services at no cost. Approximately 24% of seniors pay a full fee.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- 91 core BH programs operate across BC, serving over 260 communities, including First Nations communities (Cowichan Elders, Gitxsan First Nation, Stó:lo Territory, and Squamish-Tsleil-Waututh Nation).[1]
- BH services are provided by local non-profit organizations and delivered by a mix of volunteers, contractors, and staff.
- From April 1, 2021, to March 31, 2022, BH delivered 255,082 services to 12,888 seniors and Elders.[2] This represents a 33.4% increase in services delivered, and a 8.0% increase in number of seniors and Elders served compared to 2019/20 (191,147 services and 11,935 seniors).

FINANCIAL IMPLICATIONS

Since 2011/12, the Ministry and the Provincial Health Services Authority provided $113 million to the UWBC to expand and operate the BH program: $15 million in 2011/12; $5 million in 2012/13; $2 million in 2013/14; $4 million in 2014/15; $5 million in 2015/16; $10 million in 2016/17; $10 million in 2017/18; $6.6 million in 2018/19; and $55.4 million in 2019/20 ($50 million announced), Advice/Recommentations; Government Financial Information

KEY BACKGROUND

- Program sites are selected based on criteria (i.e., proportion of seniors, number of seniors likely to require BH services) and guidance from seniors' organizations and local and regional experts.
- Local circumstances determine sliding-scale fee structure and services available. Eligible seniors with low-income receive services at no cost. Approximately 24% of seniors pay a full fee.[4]
- The current programs are (entries in **bold** represent programs added in 2022/23)[5]:

No.	Program Name	Program location	No.	Program Name	Program location
Fraser Health Region (15 programs)					
1	Abbotsford BH	Abbotsford	9	New Westminster BH	New Westminster
2	Burnaby BH	Burnaby	10	South Surrey/White Rock BH	Surrey
3	Chilliwack BH	Chilliwack	11	Stó:lo Territory BH	Agassiz
4	Delta BH	Delta	12	Surrey-Newton BH	Surrey
5	Hope/Fraser Canyon BH	Hope	13	Surrey-Whalley BH	Surrey
6	Langley BH	Langley	14	Tri-cities BH	Port Moody
7	Maple Ridge/Pitt Meadows BH	Maple Ridge	15	Agassiz-Harrison BH*	Agassiz
8	Mission BH	Mission		*This program represents a split from the Chilliwack BH program.	
Interior Health Region (26 programs, including 3 new programs)					
1	Arrow Lakes BH	Nakusp	12	Lower Columbia BH	Trail
2	Ashcroft/Cache Creek BH	Kamloops	13	Nelson BH	Nelson
3	Boundary BH	Grand Forks	14	North Okanagan BH	Vernon
4	Castlegar BH	Castlegar	15	North Thompson BH	Clearwater
5	Central Okanagan BH	Kelowna	16	Penticton BH	Penticton
		West Kelowna	17	Shuswap Region BH	Sicamous
		Lake Country	18	South Okanagan BH	Oliver & Osoyoos
6	Columbia Valley BH	Invermere	19	Williams Lake BH	Williams Lake
7	Cranbrook BH	Cranbrook	20	Peachland BH	Peachland
8	Creston Valley BH	Creston	21	Golden BH	Golden
		Crawford Bay	22	Princeton BH	Princeton
9	Kamloops BH	Kamloops	23	Nicola Valley BH	Merritt
10	Logan Lake BH	Logan Lake	24	Revelstoke BH	Revelstoke

[1] United Way British Columbia email correspondence, January 16, 2023.

[2] United Way British Columbia email correspondence October 13, 2022. Includes data correction of 10,192 services and 112 clients from previous report due to UWBC reporting error.

Advice/Recommentations; Government Financial Information

[4] United Way British Columbia email correspondence, January 16, 2023.

[5] Ibid.

LEGISLATIVE SESSION – ESTIMATES NOTE

No.	Program Name	Program location	No.	Program Name	Program location
11	**Southern Cariboo BH**	**100 Mile House**	**25**	**Elk Valley BH**	**Invermere**
			26	**Slocan Valley BH**	**Slocan**
Northern Health Region (15 programs, including 2 new program)					
1	Dawson Creek BH	Dawson Creek	9	Prince Rupert BH	Prince Rupert
2	Fort St. John BH	Fort St. John	10	Quesnel BH	Quesnel
3	Gitxsan BH	New Hazelton	11	Robson Valley BH	Fort St. James
4	Granisle BH	Granisle	12	Terrace BH	Terrace
5	Kitimat BH	Kitimat	13	Houston BH	Houston
6	North Central BC BH	Fraser Lake	14	Burns Lake BH	Burns Lake
7	**Chetwynd BH**	**Chetwynd and Tumbler Ridge**	**15**	**Mackenzie BH**	**Mackenzie**
8	Prince George BH	Prince George			
Vancouver Coastal Health Region (16 programs, including 1 new program)					
1	Hastings-Sunrise BH	Vancouver	9	Richmond BH	Richmond
2	Kitsilano BH	Vancouver	10	Sea to Sky BH	Squamish
3	KOMDS BH	Vancouver	11	Vancouver Inner City BH	Vancouver
4	Mount Pleasant BH	Vancouver	12	Sunshine Coast BH	Sechelt
5	Wavefront Centre BH	Vancouver	13	Squamish Nation-Tsleil-Waututh Nation BH	Squamish
6	Powell River BH	Powell River	14	Vancouver South BH	Vancouver
7	Renfrew-Collingwood BH	Vancouver	15	West End & Coal Harbour BH	Vancouver
8	North Shore BH	North Vancouver	**16**	**Pender Harbour BH**	**Madeira Park**
Vancouver Island Health Region (19 programs)					
1	Campbell River BH	Campbell River	10	Salt Spring Island BH	Salt Spring Island
2	Comox Valley BH	Hornby Island	11	Oceanside BH	Parksville
3	Cowichan Region BH	Duncan	12	Port Alberni BH	Port Alberni
4	Cowichan Elders BH	Duncan	13	Saanich BH	Saanich
5	Esquimalt BH	Victoria	14	Cortes Island BH	Cortes Island
6	Galiano BH	Galiano Island	15	Sooke BH	Sooke
7	Nanaimo BH	Nanaimo	16	Southern Gulf Islands BH	Pender Island
8	North Island BH	Port Hardy	17	Victoria and Oak Bay BH	Victoria
9	Quadra Island BH	Quadra Island	18	West Shore BH	Victoria
			19	Pacific Rim BH	Tofino

LAST UPDATED

The content of this fact sheet is current as of March 23, 2023 as confirmed by Kiersten Fisher.

APPROVALS

2023 03 10 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 03 27 - Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Caregiver Support

Topic: Caregiver support provides relief from the emotional and physical demands of caregiving and includes in-facility (overnight) respite, adult day programs, and in-home respite visits.

Key Messaging and Recommended Response:

- **We have invested $145 million over the last 5 years to expand respite care and adult day programs, helping both seniors and their loved ones.**
- **As of December 31, 2022 – 113 out of 123 adult day program sites have re-opened after closures required during the COVID-19 pandemic.**
- **Like other areas of health care, there are human resource challenges, which is why we are implementing our Health Human Resources Strategy.**

CURRENT SITUATION

- The Office of the Seniors Advocate report, *We Must Do Better*, released in February 2023, recommended that respite care for home support clients be increased to meet the needs of family caregivers.
- The Ministry is exploring options to enhance supports for caregivers, including examining utilization of current services with an eye to modernization to meet client and caregiver needs.

Adult Day Programs (ADP)

- As of December 31, 2022, 113 out of 123 adult day program sites across the Province had re-opened following pandemic closures, providing 27,509 out of the 33,945 spaces that were available at pre-pandemic operating capacity. The following number of sites/spaces are open: Fraser – 17 sites/7,676 spaces[1]; Interior – 34 sites/6,540 spaces; Vancouver Island – 26 sites/4,523 spaces; Vancouver Coastal – 21 sites/7,220 spaces[2]; Northern – 15 sites/1,550 spaces.[3]
- Fraser Health and Vancouver Coastal Health have retained virtual day programming, which was introduced during the pandemic, to support clients who may be unable to attend in person.
- ADP capacity is recovering from pandemic service suspensions. YTD[4] 2022/23, approximately 6,271 British Columbians (127% increase from 2021/22; 10% increase from 2016/17 baseline) received a total of 172,484 days of services (182% increase from 2021/22; 18% below the 2016/17 baseline).[5]
- Return to pre-pandemic ADP capacity has been challenged due to compounding factors: staffing shortages, inclement weather (directly impacting availability for December 2022), temporary facility closures, changing attitudes of clients to prefer 1:1 care in their homes vs. group settings, and clients unable to secure reliable transportation to/from programs.
- Prior to the pandemic, 2019/20 ADP service volumes had reflected increased investment and rising service delivery levels with a total of 7,505 British Columbians receiving ADP services (a 22% increase from 2016/17 baseline) with 292,031 days of ADP provided (a 21% increase from 2016/17 baseline).[6]

Overnight/In-Facility Respite

- Admissions to in-facility respite are open with symptom screening for unvaccinated clients.

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[1] Virtual ADP included in total available spaces, currently utilized at 16 sites.
[2] Virtual ADP included in total available spaces, currently utilized at 8 sites.
[3] ADP Re-opening Report, P9, 2022/23 with baseline data derived from P13, 2020/21
[4] Year to Date 2022/23 data includes service volumes and client counts up to Period 12 (Period 12 of 13).
[5] HSIAR, Home and Community Care Progress Report, 2022/23 Period 12, last accessed April 17, 2023.
[6] HSIAR, Home and Community Care Progress Report, 2022/23 Period 12, last accessed April 17, 2023.

- In-facility respite capacity is recovering from pandemic service suspensions. YTD[7] 2022/23, approximately 2,721 British Columbians (34% increase from 2021/22; 17% below the 2016/17 baseline) received a total of 70,357 days of services (24% increase from 2021/22; 27% below the 2016/17 baseline).[8]
- Regional health authorities report workforce shortages, long-term care admissions, prioritization of beds to support ALC/acute patients, and lack of family physicians to support the admission for respite (i.e., review and confirm medications) are impacting service delivery.
- Prior to the COVID-19 pandemic, home and community care investment saw increasing availability of in-facility respite with a total of 3,503 clients receiving overnight respite in 2019/20, an 8% increase from baseline in 2016/17.[9]

FINANCIAL IMPLICATIONS

- Budget 2021 provides $68 million over the 3 years of the fiscal plan ($22.5 million annually) to increase support for home care services, including increasing care aides and community providers.
- The Ministry of Health invested $145 million over the last 5 years to expand respite care and adult day programs, helping both seniors and their loved ones.
- The Ministry doubled funding for Family Caregivers of BC providing approximately $1 million in 2020/21, helping support both caregivers and seniors as part of BC's emergency COVID-19 response plan.

KEY BACKGROUND

- A 2017 Seniors Advocate's report, *Caregivers in Distress: A Growing Problem*, recommended increasing access to caregiver supports including ADP and in-home and overnight respite.
- ADPs are group programs provided in a community setting. Clients receive a range of personal care, health care, and therapeutic social/recreational activities and caregivers receive a break from caregiving duties.
- On March 18, 2020, the Ministry suspended all health authority funded/operated ADPs across BC to help prevent the spread of COVID-19 and prioritize healthcare resource allocation.
- In-facility respite provides short term care for clients in a licensed long-term care home. This supports caregivers by enabling time away from caregiving while clients receive safe, professional care.
- On March 18, 2020, health authorities were advised to temporarily suspend in-facility respite, except in circumstances of intolerable risk and on July 12, 2021, the Ministry advised all health authorities to resume in-facility respite services with mandatory isolation requirements for those not vaccinated.
- As of August 31, 2022, the guidance for unvaccinated in-facility respite clients changed to monitoring for symptoms for 10 days.

<u>Seniors' Guide</u>

- The BC Seniors' Guide (the Guide) is an invaluable resource for seniors and caregivers, providing information about services and supports available throughout the Province.
- Since 2016/17, the Guide has been translated into five additional languages (Farsi, Korean, Vietnamese, Hindi, and Tagalog).
- The 11th Edition was reviewed and updated in 2020/21 with the 12th Edition released in May 2020.
- The 12th and current Edition is available (print and electronic) in nine languages and contains contemporary information regarding digital literacy, cultural safety, LGBTQ2S+ support, medical assistance in dying, housing, transportation, finances, safety, and more.

<u>Family Caregivers of BC</u>

Family Caregivers of BC is a non-profit organization dedicated to supporting informal and unpaid caregivers. They assist with navigating the health care system, offer education and information, facilitate emotional support groups, and operate a toll-free caregiver support line.

[7] Year to Date 2022/23 data includes service volumes and client counts up to Period 12 (Period 12 of 13).
[8] HSIAR, Home and Community Care Progress Report, 2022/23 Period 12, last accessed April 17, 2023.
[9] HSIAR, Home and Community Care Progress Report, 2022/23 Period 12, last accessed April 17, 2023.

LEGISLATIVE SESSION – ESTIMATES NOTE

LAST UPDATED

The content of this fact sheet is current as of March 6, 2023, as confirmed by Kiersten Fisher, Executive Director, Seniors' Services Branch.

APPROVALS

2023 03 15 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03 30 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 18 – Ross Hayward, Seniors Services' Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Home and Community Care (HCC) Seniors Funding

Topic: The Ministry of Health invests significant funding in programs and services to support seniors and individuals with complex medical conditions or frailty.

Key Messaging and Recommended Response:

- **Since 2017, the province has invested approximately $2 billion to improve care for seniors, including investments in primary care, home health, long-term care, assisted living and respite services.**
- **The recent funding also expanded training for health-care assistants to address critical staffing shortages in the long-term care, assisted living and home care sectors with $25 million in 2022-23.**
- **This will allow the province to hire more than 5,000 new health-care assistants by 2022-23 and provide new opportunities for workers who lost their jobs in other sectors due to COVID-19.**

CURRENT SITUATION

Government Financial Information

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- In addition to base funding for LTC, the Ministry has provided the following funding to the LTC sector in response to the COVID-19 pandemic and other pressures:
  - Wage leveling, COVID-19 costs (OT, supplies), visitor screening, and stabilization funding.
- The Ministry has made significant investments in the non profit sector to provide seniors with non medical supports they need to age well at home, including increased investments in response to the COVID-19 pandemic.
  - In 2019/20, $55.4 million was provided to United Way BC (UWBC) to deliver Better at Home; expand the Higher Needs Grants demonstration projects; and deliver the Safe Seniors, Strong Communities program that provided non-medical services to seniors whose regular support network was disrupted by the COVID-19 pandemic, or whose need for support increased due to self-isolation.
  - In 2022/23, $70M was provided to UWBC to continue to deliver Better at Home and Higher Needs Grants demonstration projects; to advance regional coordination and partnership between the Community-based Seniors' Services sector and other senior-serving agencies, enhancing volunteer capacity, and improving the ability for communities to mobilize and support older adults in climate emergencies; and to build new community supports focused on connecting older adults to local resources. **NOT YET ANNOUNCED**

- In addition to funding provided through HAs and UWBC, the Ministry provides a number of grants to non profit organizations to support seniors, some of which include:
    - In 2019/20, $10 million was provided to the BC Care Providers Association to support and expand the EquipCare BC program; a component of which was used to create an Infection Control Enhancement Program to support publicly funded and private LTC and AL operators to respond to the COVID-19 pandemic and improve infection prevention.
    - In 2021/22, $8 million Government Financial Information was provided to the BC Care Providers Association to continue supporting publicly-funded LTC and AL residence operators to respond to the COVID-19 pandemic and improve infection prevention and extreme weather events in the sector.

Government Financial Information

- Funding for the Office of the Seniors Advocate (OSA), an independent office of the BC provincial government is also provided through the Ministry of Health. In 2022/23, the Ministry provided $2.69 million for the OSA to undertake work related to monitoring and analyzing senior services and issues in BC and making recommendations to government and service providers to address systemic issues.

FINANCIAL IMPLICATIONS

We have invested approximately $2 billion over the past five years to improve care for seniors, including investments in primary care, home health, long-term care and assisted living.

KEY BACKGROUND

- Funding is provided through health authorities to deliver home and community care services, including home support, community professional services (e.g., nursing, rehab, social work), respite (e.g., adult day programs), assisted living, long term care and palliative care.
- Additionally, the Ministry provides funding through non profit community-based seniors serving organizations to support seniors with non-medical supports they need to age well in the community.

LAST UPDATED

The content of this fact sheet is current as of 2023 04 14 as confirmed by Danielle Prpich, Executive Director, Long-term Care and Assisted Living Strategy and Policy.

APPROVALS

2023 04 13 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 14 - Danielle Prpich obo Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Home Health

Topic: BC has a comprehensive range of home health services that support seniors, as well as people experiencing short- or long-term disability, to manage their health care needs and remain living at home in their community.

Key Messaging and Recommended Response:

- **My mandate letter includes a commitment to increase support for home health care.**
- **Policy development is underway to achieve the mandate commitment, including: proposed changes to improve the responsiveness of services to clients (hours of coverage, response times); more flexibility of services offered; increasing the number of care aides; initiatives to increase the consistency of care workers that visit a client; review of the client rate structure and alternative funding models.**
- **YTD 2022/23[1], approximately 10,390,900 hours of HS were delivered, which is 3% less than 2021/22 and a 4% increase over 2016/17.[2]**

CURRENT SITUATION

- Health authorities (HAs) are managing longstanding workforce shortages due to shifting population demographics, competition for workers between industries/sectors, illness and generalized fatigue/burnout.
- Mitigation strategies employed by HAs to maintain client health and safety throughout workforce shortages include: daily prioritization of client visits, reduced frequency and/or shortened visits, cancellation of lower priority visits, redeployment of staff between services and communities, use of virtual care where possible and appropriate, use of overtime, focused efforts on ongoing recruitment, and contracted service provision where necessary to maintain continuity of service.
- Despite workforce shortages, a steady increase in service provision has been achieved:
    - YTD 2022/23[1]: approximately 1,543,150 Community Based Professional Service (CBPS) visits were provided by HAs across the province, a decrease of 2% from 2021/22 and an increase of 20% over 2016/17.[1] Services were provided to approximately 131,500 British Columbians, a 2% decrease over 2021/22 and a 17% increase over 2016/17.[1]
    - YTD 2022/23[1]: approximately 10,390,900 hours of home support (HS), including assisted living, were provided by HAs across the province, a decrease of 3% over 2021/22 and an increase of 4% over 2016/17.[1] Services were provided to approximately 52,100 British Columbians, with no change (0%) over 2021/22 and a 7% increase over 2016/17.[1]
- As of February 2023, 822 Health Care Support Workers were hired by regional HAs, since September 2020, to work in home health through the Health Career Access Program (HCAP)[3] (X-Ref HCAP Estimates Note).

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[1] YTD 2022/23 captures annual service and client count data up to Period 12 (12 of 13 reporting periods) ending March 2, 2023. Full year 2022/23 annual service volumes and client counts are not yet available.
[2] HSIAR, Home and Community Care Progress Report Period 12. Last accessed April 18, 2023.
[3] Report on HCAP Home Health hires compared to other settings, January 19, 2023, HSWBS.

- The Office of the Seniors Advocate (OSA) conducted a home support client and caregiver survey December 2021 through March 2022, and a report on findings and recommendations was released on February 23, 2023.
- The Ministry has supported the regional HAs to implement strategies to create capacity in home health and reduce the number of Alternate Level of Care (ALC) patients during the fall/winter surge, including the implementation of rapid response teams in the community and provision of 24/7 home support where appropriate.

FINANCIAL IMPLICATIONS

- Budget 2021 provides:
  - $68 million over 3 years of the fiscal plan ($22.5 million annually) to increase support for home care services, including increasing care aides and community providers.
  - $12 million over three years for the Home Health Monitoring Initiative which supports patients to self-manage their health from the comfort of their homes.
  - $585 million over three years to support the HCAP.
- In 2021/22, HAs reported spending more than $1.9 billion on community care services, including adult day services, professional services (nursing and rehabilitation), home support, case management and assisted living services.
- The Ministry invested $145 million over the last 5 years to expand respite care and adult day programs, helping both seniors and their loved ones.

KEY BACKGROUND

- Premier Eby's December 7, 2022, mandate letter to Minister Dix calls to: *'expand publicly funded home care'*.
- Policy development is underway to achieve the mandate commitment, including: proposed changes to improve the responsiveness of services to clients (hours of coverage, response times); more flexibility of services offered (IADLs); increasing the number of care aides (HCAP); initiatives to increase the consistency of care workers that visit a client; review of the client rate structure and alternative funding models.
- A key component of the Ministry's approach to home health is the implementation of Specialized Community Service Programs in the HAs, which will improve the coordination of services and integration of home health with other primary care and community-based services.

Community Based Professional Services (CPBS)

CBPS are provided by regulated health care professionals and include nursing, rehabilitation (occupational and physical therapy), and social work. CBPS include assessment, care planning, care provision, and case management, with emphasis on early intervention, post hospital discharge and prevention of readmission through linkages with primary care networks, and case monitoring to support people to live independently in the community.

Home Support (HS) Services

- HS services are provided by unregulated care providers (Health Care Assistants [HCAs] / Community Health Workers [CHWs]) to clients who require assistance with activities of daily living (e.g., personal care, mobilization). Services may also include safety maintenance activities (e.g., cleaning spills or laundering), delegated nursing and rehabilitation tasks as required, and in-home respite.
- HAs are working to increase service hours for long-term HS clients to enable independent living for as long as possible, and also for short-term home support clients (i.e., following hospital discharge).
- The HCAP, announced in September 2020, is a work integrated learning program designed to increase the supply of HCAs and provide opportunities for British Columbians to access careers in the health sector. Participants are hired into a non-direct care role and funded for the education to become a registered HCA by program end.

- Service redesign in some geographic areas is underway to improve continuity of care within communities through:
    - the implementation of neighbourhood models of care, where teams of healthcare providers collaborate within set geographic areas to support clients throughout the day; and,
    - enhancing scheduling strategies, including geographic and fixed shift scheduling, to support retention of CHWs by focusing on consistency of shifts, and increasing capacity to ensure responsive, client-focused care.
- Some eligible HS clients receive support through the Choice in Supports for Independent Living (CSIL) program (X-Ref CSIL Fact Sheet), a self-directed option for clients with high-intensity care needs.
- In 2020, VCH, FHA, and VIHA completed repatriation of HS services from contracted service providers leading to improved coordination and care accountability. Contract services may still be used during peak demand periods.

Office of the Seniors Advocate: Home Support Review Report

- On February 23, 2023, the OSA released a report on HS services with the following recommendations:
    1. Eliminate the financial barrier to home support access.
    2. Increase respite care.
    3. Standardize and set targets for all aspects of service delivery.
    4. Modernize care plans.
    5. Measure, monitor and report performance.
- These recommendations align with the Ministry's work, and are informing ongoing policy development.

LAST UPDATED

The content of this fact sheet is current as of April 18, 2023 as confirmed by Alix Adams, A/ED.

APPROVALS

2023 03 10 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03 28 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 19 – Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Licensed Community Care Facilities – Child Care

Topic: Community care facilities are regulated under the *Community Care and Assisted Living Act* (CCALA) and are licensed through regional health authorities (HAs).

Key Messaging and Recommended Response:

- **Our health-care system includes a robust network of private and subsidized community care facilities that are regulated under the Community Care and Assisted Living Act (CCALA) and licensed through the regional authorities.**
- **There are several different types of licensed care under the CCALA, including child day care, child and youth residential care and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long Term Care, Mental Health and Substance Use.**
- **There are 7,508 child care facilities throughout BC that provide children the services they need in the comfort of their communities.**

CURRENT SITUATION

- Licensed community care facilities include both publicly subsidized and private pay models.
- In May 2021, government created two new licensed categories of care: School Age Care on School Grounds and Recreation Care. The school age category has been well-received with its streamlined requirements with a substantial uptake of 75 licenses issued since August 2022

December 31, 2022*	FHA	IHA	VIHA	NHA	VCHA	BC
Facility Service Type						
Group Child Care < 36 months	471	151	173	56	292	**1,143**
Group Child Care > 30 months	650	255	336	87	413	**1,741**
Group Child Care School Age	428	244	208	56	260	**1,196**
Preschool	369	169	158	71	178	**945**
Family Child Care	299	177	261	144	207	**1,088**
Occasional Child Care	43	36	10	1	24	**74**
In-Home Multi Age Child Care	171	57	84	33	68	**413**
Multi Age Child Care	363	147	115	66	88	**779**
Child-minding	12	2	2	1	3	**20**
School Age Care on School Grounds	114	15	58	24	27	**238**
Recreational Care	3	1	2	0	0	**6**
Total	2,883	1,254	1,407	539	1,560	**7,643**

* HA data reported indicates 53 57 less Group Child Care School-Age facilities, however this fluctuation is thought to be from operators shifting to School Age Care on School Ground, which reflects an increase of 71- 75 School Age Care on School Grounds.
Waiting for data from 2 HAs , will not significantly impact the final number may increase or decrease by 1 or 2 facilities.
IHA numbers from Aug 15,2022 are not correct as the final reported. Correct total = 1278 Correct numbers included in Dec 31,2022 reporting period.

LEGISLATIVE SESSION – ESTIMATES NOTE

FINANCIAL IMPLICATIONS

N/A

KEY BACKGROUND

There are several different types of licensed care under the CCALA, including child day care, child and youth residential care, and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long-Term Care, Mental Health and Substance Use.

August 15 ,2022	FHA	IHA[1]	VIHA	NHA	VCHA	BC
Facility Service Type						
Group Child Care < 36 months	437	145	146	49	269	**1,046**
Group Child Care > 30 months	614	246	310	83	402	**1,655**
Group Child Care School Age	462	240	246	88	270	**1,306**
Preschool	386	175	162	74	182	**979**
Family Child Care	324	196	310	152	218	**1,200**
Occasional Child Care	4	35	13	3	24	**78**
In-Home Multi Age Child Care	162	50	84	31	64	**391**
Multi Age Child Care	352	142	99	67	78	**738**
Child-minding	13	2	3	1	3	**22**
School Age Care on School Grounds	57	3	12	8	12	**92**
Recreational Care	1	0	0	0	0	1
Total	2,812	1,234	1,385	556	1,521	**7,508**

LAST UPDATED

The content of this fact sheet is current as of March 17, 2023, as confirmed by Sue Bedford.

APPROVALS

2023 03 17 - Sue Bedford, Assisted Living Registry and Community Care Licensing
2023 03 17 - Ross Hayward, Seniors' Services Division

[1] Interior Health has not provided updated data as of Sept 28th

LEGISLATIVE SESSION – ESTIMATES NOTE

Licensed Community Care Facilities – Residential Care (All Categories)

Topic: Community care facilities are regulated under the *Community Care and Assisted Living Act* (CCALA) and are licensed through the regional health authorities (HAs).

Key Messaging and Recommended Response:

- **Our health-care system includes a robust network of private and subsidized community care facilities that are regulated under the Community Care and Assisted Living Act and licensed through the regional authorities.**
- **There are several different types of licensed care under the Community Care and Assisted Living Act, including child day care, child and youth residential care and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long Term Care, Mental Health and Substance Use.**
- **There are 1,130 facilities throughout BC that provide patients timely services they need close to home.**

CURRENT SITUATION

- HAs provide monthly data to the Community Care Facility Licensing branch of the Ministry of Health on the number of facilities under each service type, described in the CCALA and its Regulations.
- Licensed community care facilities include both publicly subsidized and private pay models.

[1]December 31, 2022	FHA[2]	IHA	Island[3]	NHA	VCHA	BC
Facility Service Type						
Acquired Injury	12	7	2	1	10	**32**
Child and Youth Residential	14	4	11	18	20	**67**
Community Living	157	92	123	30	87	**489**
Hospice	7	4	2	1	6	**20**
Long Term Care[4]	68	69	67	12	51	**265**
Mental Health	33	9	14	3	45	**104**
Substance Use	16	10	7	0	17	**50**
Hospital Act	24	16	30	12	17	**87**
Mental Health and Substance Use	0	8	0	4	1	**13**
Total	***331***	***219***	*242*	***81***	***254***	***1,127***

FINANCIAL IMPLICATIONS

N/A

[1] Data is current to December 31, 2022Source: HCC Long-Term Care & Assisted Living Summary Report, as of December 2022(for Acquired Injury, Hospice, and Long-Term Care), and HA Community Care Facility Licensing programs (for the remaining 5 service types)
[2] Fraser Health reports each service type separately, therefore the sum of facilities by service types is more than the number of individual facilities.
[3] Island Health reports by primary service type. Some facilities will have more than one service type at a premise, but only the dominant service type is counted.

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

There are several different types of licensed care under the CCALA, including child day care, child and youth residential care, and care for specialized populations including Acquired Brain Injury, Community Living, Hospice, Long Term Care, Mental Health, and Substance Use. The tables below provide facility counts by type and HAs.

[5]August 15, 2022	FHA[6]	IHA	Island[7]	NHA	VCHA	BC
Facility Service Type						
Acquired Injury	12	9	2	1	9	**33**
Child and Youth Residential	15	7	11	18	20	**72**
Community Living	160	95	125	27	87	**492**
Hospice	7	4	2	1	6	**20**
Long Term Care[8]	92	84	82	24	68	**350**
Mental Health	33	8	14	0	45	**100**
Substance Use	19	8	7	0	17	**52**
Mental Health and Substance Use	0	8	0	4	1	**11**
Total	***338***	***221***	*243*	***75***	***253***	***1,130***

LAST UPDATED

The content of this fact sheet is current as of February 23, 2023, as confirmed by Sue Bedford.

APPROVALS

2023 02 21 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 02 23 - Sue Bedford, Assisted Living Registry and Community Care Licensing, Seniors' Services Division
2023 03 01 - Ross Hayward, Seniors' Services Division

[5] Data is current to December 31, 2022. Source: HCC Long-Term Care & Assisted Living Summary Report, as of December2022 (for Acquired Injury, Hospice, and Long-Term Care), and HA Community Care Facility Licensing programs (for the remaining 5 service types)
[6] Fraser Health reports each service type separately, therefore the sum of facilities by service types is more than the number of individual facilities.
[7] Island Health reports by primary service type. Some facilities will have more than one service type at a premise, but only the dominant service type is counted
8. An additional column of Hospital Act has been added, the total number does not reflect the number of facilities as they may be included under LTC or Hospice therefore accounting for what appears to be an increase.
9. Waiting for data conf9irmation from Island Health, would not sustainably alter reported numbers.

LEGISLATIVE SESSION – ESTIMATES NOTE

Long-Term Care Staffing (3.36 Hours per Resident Day - HPRD)

Topic: Summary of the impact of *Budget 2018* allocation of $240 million over 3 years to increase direct care hours in long-term care (LTC) facilities.

Key Messaging and Recommended Response:

- **Our government remains committed to providing the highest quality health-care, especially in Long-Term Care (LTC).**
- **In 2017, government released the *Residential Care Staffing Review Report* which examined the state of LTC service delivery with a focus on staffing levels and staffing mix.**
- **The report concluded a minimum of 3.36 Hours per Resident Day, on average, across each health authority is required for safe, quality care.**
- **Since 2017, the province has invested approximately $2 billion to improve care for seniors, including investments in primary care, home health, long-term care, assisted living and respite services.**
- **The funding allocates $75 million over three years for various initiatives to ensure seniors in BC have access to the supports and services they need. The funding also expands training for health-care assistants to address critical staffing shortages in the long-term care, assisted living and home care sectors with $25 million in 2022-23.**
- **Budget 2018 allocated $240 million over three years (2018/19 - $50 million; 2019/20 - $80 million; 2020/21 $110 million) to increase direct care hours in LTC facilities to ensure each health authority will reach the target of 3.36 Hours per Resident Day, on average, across all facilities by 2021.**
- **The year three investment of $110 million continues as part of the Ministry of Health's base budget.**
- **As of fiscal year 2020/21, all five regional health authorities were funded to meet or exceed the target of 3.36 Hours per Resident Day, on average, across all facilities; and all five met or exceeded this target in 2020/21 for the first time which is a massive accomplishment**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- Budget 2018 allocated $240 million over 3 years (2018/19 - $50 million; 2019/20 - $80 million; 2020/21 - $110 million) to increase direct care hours in LTC facilities to ensure each health authority will reach the target of 3.36 Hours per Resident Day (HPRD), on average, across all facilities by 2021.
- The year 3 investment of $110 million continues as part of the Ministry of Health's base budget.
- As of fiscal 2020/21, all 5 regional health authorities were **funded** to meet or exceed the target of 3.36 HPRD, **on average**, across all facilities; and all 5 met or exceeded this target in 2020/21 for the first time.
- In 2021/22, a decision was made to expand the target to fund all LTC facilities at 3.36 HPRD (i.e., bring 59 facilities that remained below 3.36 as of April 1, 2021, up to the target). Implementation occurred part-way through fiscal year 2021/22, and therefore, as of April 1, 2022, all 295 publicly funded LTC facilities across the Province are funded to meet, at a minimum, the standard of 3.36 HPRD.
- Total cost of 3.36 HPRD investment in 2022/23 is $113.6 million.
- In 2022/23, the provincial average funded HPRD is 3.42, an increase of 0.31 HPRD from the 2016/17 provincial average HPRD of 3.11. Further, in 2016/17, the number of facilities meeting or exceeding 3.36 HPRD was 44 (of 293) or 15% and in 2022/23, 295 facilities (of 295) or 100% are funded to meet or exceed 3.36 HPRD.

FINANCIAL IMPLICATIONS

In 2022/23, the annual incremental HPRD investment will total $113.6 million, and all 295 facilities are funded at a minimum 3.36 HPRD effective April 1, 2022.

KEY BACKGROUND

- In 2017, the Ministry of Health released the Residential Care Staffing Review Report which examined the state of LTC service delivery with a focus on staffing levels and staffing mix. The report concluded a minimum of 3.36 HPRD, on average, across each health authority is required for safe, quality care. The target of 3.36 comprises 3.0 hours of direct nursing care (including health care assistants) and 0.36 hours of direct allied health care.
- Funding to health authorities for direct care staffing to achieve HPRD targets is calculated based on 100% bed occupancy (i.e., bed days), thereby ensuring sufficient funding is allocated so the HPRD target can be met when the facility is fully occupied. This is the funded HPRD.
- Actual HPRD however, takes into account the direct care provided, based on the beds that are occupied (i.e., resident days). When occupancy levels fall below 100%, residents receive a higher number of care hours. HPRD based on resident days (rather than 100% occupancy) is a more accurate reflection of direct care provided to residents.
- As of Q2 in 2022/23 (as shown in Table 1 and 2):
    - All 5 health authorities are forecasting to exceed the HPRD target in 2022/23 based on resident days (i.e., actual bed occupancy) resulting in an average BC level forecast HPRD of 3.51.
    - Forecasted bed occupancy rates range from 90.9% (in Interior Health) to 98.8% (in Vancouver Coastal Health), with a BC average of 96.2%.
    - All 295 facilities are funded to meet or exceed the 3.36 HPRD target; however, 71 facilities (24%) are forecasting to not achieve the target.
    - There are no facilities funded below 2.90 or 3.00; nor forecasting to be below 2.90 or 3.00.

LEGISLATIVE SESSION – ESTIMATES NOTE

HPRD				Occupancy Rate	
Table 1	2016/17 Baseline	2022/23		2022/23	
		Funded Budget @ April 1/22	Q2 Forecast ~ based on resident days	Funded Budget @ April 1/22	Q2 Forecast
FHA	3.05	3.41	3.47	100%	97.3%
VCHA	3.03	3.47	3.53	100%	98.8%
VIHA	3.13	3.41	3.45	100%	96.6%
IHA	3.23	3.39	3.60	100%	90.9%
NHA	3.39	3.45	3.63	100%	98.7%
Total	3.11	3.42	3.51	100%	96.2%

# of facilities with HPRD less than or greater/equal 3.36 by ownership type									
Table 2	2016/17 Baseline			2022/23 Funded Budget			2022/23 ~ Q2 Forecast HPRD based on resident days		
	< 3.36	>= 3.36	Total	< 3.36	>= 3.36	Total	< 3.36	>= 3.36	Total
O&O	74	33	107	0	110	110	28	82	110
PFP	101	1	102	0	102	102	31	71	102
PNP	74	10	84	0	83	83	12	71	83
Total	249	44	293	0	295	295	71	224	295
		15%			100%			76%	

- Similar to 2021/22, in 2022/23, COVID-19 continues to impact the LTC sector and the ability of facilities to consistently achieve 3.36 HPRD including:
  - Reduced/closed bed capacity, and for some facilities, the closed bed capacity was for extended periods of time.
  - Staffing challenges related to Single Site Order implementation, staff illness, mandatory vaccination, and attrition.
  - Challenges in recruiting staff during the pandemic, and provincial, national & international shortages of some disciplines (e.g., nursing).
- Health authorities are working to mitigate staffing shortages by:
  - using overtime and/or restructuring staff leaves;
  - actively recruiting for direct care staff;
  - utilizing agencies for staff;
  - management staff providing direct care to residents; and
  - utilization of the Health Career Access Program.
- Occupancy rates in the LTC facilities across the Province continues to be below 100%, due to suspending admissions during periods of outbreak or due to staffing challenges.

LAST UPDATED

The content of this fact sheet has been updated, as confirmed by Danielle Prpich.

APPROVALS

2023 02 21 – Danielle Prpich, Seniors' Services Division
2023 02 25 – Rob Byers, Finance and Corporate Services Division
2023 03 01 – Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Multi-Bed Rooms

Topic: The Ministry of Health has a mandate commitment to reduce the number of multi-bed rooms in health-authority operated Long-term Care (LTC) facilities.

Key Messaging and Recommended Response:

- **Minister of Health mandate commitment to work toward eliminating multi-bed rooms in HA operated LTC homes.**
- **Standards for health, safety and dignity requires a minimum of 95% of LTC bedrooms to be single occupancy.**
- **The remaining 5% of rooms are to accommodate couples.**

CURRENT SITUATION

- The Ministry of Health has engaged HAs to identify all licensed LTC facilities with multi-bed rooms, including health authority owned-and-operated, health authority contracted facilities.
- The number of multi-bed rooms in LTC data measures the impact of initiatives over time to reduce multi-bed rooms in aging facilities.
- The standard for health, safety and dignity set out in the Residential Care Regulation, requires a minimum of 95% of residents to be accommodated in single occupancy rooms:[1]
- Since 2018 the Office of the Seniors Advocate has reported data on single occupancy, double occupancy and multi-bed rooms in publicly funded LTC homes in the Long-Term Care Directory.
- In 2022/23, 77% of residents were in a private room, a 5% improvement since the initial data collection in 2017/18 (5% improvement over 5 years).
- Further progress in increasing the number of residents in private rooms will come as a result of the opening of new LTC capacity across the province. Examples of scheduled openings this year include:
    - Chenchenstway, Burnaby – opening 216 single bed rooms to assist in reducing multi-bed rooms in Fraser Health and Providence Health. (The total number of reduced multi-bed rooms will be known after the site opens as residents are voluntarily choosing to relocate.)
    - Creekside Landing, Vernon - will open 90 beds (June 2023).
    - Village by the Station, Penticton - will open 18 new single bed rooms (Sept 2023)
    - Cambie Gardens, Vancouver – opened 44 new suites to reduce multi-bed rooms at George Pearons Centre.
    - Villa Cathay, Vancouver – opening 51 beds together with VCH to reduce multi-bed rooms at Banfield Care Centre (In progress).

[1] Residential Care Regulation (gov.bc.ca)

LEGISLATIVE SESSION – ESTIMATES NOTE

The current status of LTC multi-bed rooms is noted in the following tables:

1.7 LONG-TERM CARE

1.7.2 ROOM AND BED CONFIGURATION IN PUBLICLY SUBSIDIZED LONG-TERM CARE, AT MARCH 31

	2018	2019	2020	2021	2022	% POINT CHANGE IN 5 YEARS	% POINT CHANGE IN LAST YEAR
IHA							
SINGLE OCCUPANCY ROOMS	92.8%	92.9%	93.5%	93.6%	94.1%	1.4%	0.6%
DOUBLE OCCUPANCY ROOMS	4.5%	4.5%	4.1%	4.0%	3.6%	-0.9%	-0.4%
MULTI-BED ROOMS	2.7%	2.7%	2.4%	2.4%	2.3%	-0.4%	-0.1%
FHA							
SINGLE OCCUPANCY ROOMS	87.9%	89.3%	89.9%	89.9%	90.1%	2.1%	0.2%
DOUBLE OCCUPANCY ROOMS	9.6%	8.2%	7.4%	7.5%	7.7%	-1.9%	0.2%
MULTI-BED ROOMS	2.5%	2.5%	2.6%	2.6%	2.3%	-0.3%	-0.3%
VCHA							
SINGLE OCCUPANCY ROOMS	81.0%	80.8%	81.4%	83.0%	84.6%	3.6%	1.6%
DOUBLE OCCUPANCY ROOMS	12.8%	13.0%	12.2%	11.0%	10.5%	-2.4%	-0.5%
MULTI-BED ROOMS	6.2%	6.2%	6.4%	6.1%	5.0%	-1.2%	-1.1%
VIHA							
SINGLE OCCUPANCY ROOMS	86.7%	86.7%	88.9%	91.1%	91.8%	5.1%	0.8%
DOUBLE OCCUPANCY ROOMS	6.8%	6.8%	6.6%	4.7%	4.5%	-2.4%	-0.3%
MULTI-BED ROOMS	6.5%	6.5%	4.5%	4.2%	3.7%	-2.8%	-0.5%
NHA							
SINGLE OCCUPANCY ROOMS	95.4%	95.4%	95.4%	95.2%	95.1%	-0.3%	-0.1%
DOUBLE OCCUPANCY ROOMS	3.2%	3.2%	3.2%	3.3%	3.6%	0.4%	0.2%
MULTI-BED ROOMS	1.5%	1.5%	1.4%	1.4%	1.4%	-0.1%	-0.1%
B.C.							
SINGLE OCCUPANCY ROOMS	87.6%	88.0%	89.0%	89.7%	90.3%	2.8%	0.6%
DOUBLE OCCUPANCY ROOMS	8.3%	7.9%	7.3%	6.8%	6.6%	-1.7%	-0.2%
MULTI-BED ROOMS	4.1%	4.1%	3.7%	3.5%	3.1%	-1.0%	-0.4%

NOTE(S): This data includes only publicly subsidized care homes that focus on care for seniors which are included in the Long-Term Care Directory. This includes publicly subsidized and private pay long-term care beds, and short-term care beds such as convalescent, end-of-life and respite beds. Care homes that provide specialized care such as acquired brain injury, AIDS or mental health are excluded.

SOURCE(S): Office of the Seniors Advocate. 2022 Long-Term Care Directory. [Extracted Date: November 12, 2022]

1.7 LONG-TERM CARE

1.7.3 PERCENT OF LONG-TERM CARE RESIDENTS IN SINGLE OCCUPANCY ROOMS

	2017/18	2018/19	2019/20	2020/21	2021/22	% POINT CHANGE IN 5 YEARS	% POINT CHANGE IN LAST YEAR
RESIDENTS IN SINGLE OCCUPANCY ROOMS	72%	73%	76%	77%	77%	5.0%	0.0%

NOTE(S): This data includes only publicly subsidized care homes that focus on care for seniors which are included in the Long-Term Care Directory. This includes publicly subsidized and private pay long-term care beds, and short-term care beds such as convalescent, end-of-life and respite beds. Care homes that provide specialized care such as acquired brain injury, AIDS or mental health are excluded.

SOURCE(S): Office of the Seniors Advocate. 2022 Long-Term Care Directory. [Extracted Date: November 12, 2022]

FINANCIAL IMPLICATIONS[2]

Monitoring numbers of multi-bed rooms in publicly funded LTC homes carries no financial implications.

KEY BACKGROUND

- 352 total regular LTC homes for BC as of Dec 2022 (including ABI 374)
- 31,031 total regular LTC beds for BC as of Dec 2022 (including ABI 31,200)
- On October 6, 2021, the Office of the Seniors Advocate released the report: *Review of COVID-19 Outbreaks in Care Homes in British Columbia*. The review made recommendations to reduce the probability that the virus would be introduced to a facility and if introduced, to limit the spread. Recommendations included the *elimination of shared rooms*.
- The Ministry of Health has a mandate commitment to reduce the number of multi-bed rooms in LTC facilities. This commitment is referenced in the 2020 mandate letters for both the Minister of Health and the Parliamentary Secretary for Seniors: *"…working toward eliminating multi-bed-rooms in health authority-owned long-term care facilities, giving seniors more dignity."*[3]

LAST UPDATED

The content of this fact sheet is current as of 06 April 2023 as confirmed by Danielle Prpich .

APPROVALS

2023 04 12 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 04 14 – Ross Hayward, Seniors' Services Division

[2] See Capital Funding for Long-Term Care (LTC) Renewal and Expansion Estimates Note.
[3] Minister of Health mandate letter. November 2020. https://news.gov.bc.ca/files/HLTH-Dix-mandate.pdf

LEGISLATIVE SESSION – ESTIMATES NOTE

OSA Report on Affordability for Seniors (Falling Further Behind)

Topic: BC's Office of the Seniors Advocate released a report titled *BC Seniors: Falling Further Behind* on September 22, 2022, offering a systemic review of affordability issues for seniors across BC. The report's 10 recommendations span initiatives and projects within multiple BC Ministries, including Housing, Social Development and Poverty Reduction, Transportation, and Health.

Key Messaging and Recommended Response:

- **Every senior in BC should have access to the supports and services they need to live a healthy and happy life.**
- **Since 2017, the province has invested approximately $2 billion to improve care for seniors, including investments in primary care, home health, long-term care, assisted living and respite services.**
- **These historic investments in seniors care include making the first-ever increase to the senior's supplement, nearly doubling rental payment amounts under the SAFER program, and supporting seniors to ensure they can live independently in their own homes for as long as possible and, if needed, provide the best possible living options.**
- **This included $75 million over three years to expand respite and adult day programs (ADPs).**
- **The recent funding also expanded training for health-care assistants to address critical staffing shortages in the long-term care, assisted living and home care sectors with $25 million in 2022/23.**

CURRENT SITUATION

- The report contains 3 recommendations related to Ministry of Health (MoH) programs and services:
  - #6: Eliminate the daily rate for publicly funded home support (HS) services.
  - #7: Provide an extended health benefit for seniors that includes eyeglasses, hearing aids, mobility aids and necessary medical equipment. The cost of the plan could be covered by premiums based on income, ensuring it is an affordable option for all BC seniors.
  - #10: Develop a comprehensive plan to build the capacity of seniors' centres across BC to better support social engagement and help support older people access the supports and services they need to continue to live independently.

- The following table outlines government initiatives and planned actions related to the recommendations:

Recommendation	Current Government Initiatives and Planned Actions
#6: Eliminate the daily rate for publicly funded home support services.	In 2022, 65% of long-term HS clients (over 15,000 clients) were assessed a $0 rate (i.e., no co-payment/daily rate). Clients do not pay a client rate for HS services if they receive: Income benefits, including: Guaranteed Income Supplement (GIS), Income or Disability Assistance, War Veteran's Allowance; Time-limited acute home health services, i.e., two weeks after acute discharge; BC's Palliative Care Benefits and eligible for the health authority palliative program, including approved medical supplies and equipment. If a client or their family will experience serious financial hardship by paying the assessed client rate, the client may apply for a waiver of all, or a portion, of the client rate for up to one year. Advice/Recommentations
#7: Provide an extended health benefit for seniors that includes eyeglasses, hearing aids, mobility aids and necessary medical equipment. The cost of the plan could be covered by premiums based on income, ensuring it is an affordable option for all BC seniors.	
#10: Develop a comprehensive plan to build the capacity of seniors' centres across BC to better support social engagement and help support older people access the supports and services they need to continue to live independently.	MoH has prioritized investments in the community-based seniors' services (CBSS) sector by funding programs delivered through a variety of municipal and non-profit agencies including, but not limited to, seniors centres. Provincially funded CBSS programming has included Better at Home (BH), Higher Needs Grants (HNG) demonstration projects, and the Safe Seniors, Strong Communities program, which supported seniors during the COVID-19 pandemic. Advice/Recommentations

FINANCIAL IMPLICATIONS

- All 10 report recommendations have potential financial implications across government programs.

Advice/Recommentations

- Re #10: Since 2011/12, the MoH and the Provincial Health Services Authority invested $113 million into BC's CBSS sector, through United Way BC (UWBC). Additional ad hoc funding has been delivered directly to CBSS agencies and, in 2022/23, the MoH approved an additional $70 million over 2 years to support continued BH and HNG programs and ongoing sector expansion, as outlined above. **NOT YET ANNOUNCED**

KEY BACKGROUND

The stated intention of the report was to understand the impact of rising costs on seniors. A range of government supports, services and subsidies were reviewed to determine their effectiveness, using data from a 2022 survey of low-income seniors and consultation with 82 community agencies. The 10 report recommendations include:

1. Index the BC Seniors Supplement to inflation consistent with other income supports such as GIS/Old Age Security (OAS) and Canadian Pension Plan *CPP.
2. Redesign the Shelter Aid for Elderly Renters (SAFER) program to reflect the current reality of the BC rental market and ensure yearly rent increases are recognized.
3. Increase the number of Seniors Subsidized Housing Units with a particular focus on rural BC where the overall supply of rental accommodation for seniors is most challenging.
4. Increase awareness of the Property Tax Deferral Program and examine an expansion of the program for low- and modest-income seniors to defer other costs such as strata fees, hydro costs and other municipal charges. Examine how seniors living in co-operative housing might be able to take advantage of the program.
5. Develop a program to assist low- and modest-income seniors with major home repairs.
6. Eliminate the daily rate for publicly funded home support services.
7. Provide an extended health benefit for seniors that includes eyeglasses, hearing aids, mobility aids and necessary medical equipment. The cost of the plan could be covered by premiums based on income, ensuring it is an affordable option for all BC seniors.
8. Work with the federal government to ensure dental coverage for seniors with co-payments and deductibles based on income or include in an overall extended benefit plan.
9. Provide an annual province-wide bus pass for all seniors that includes handyDART. The fee for the pass could be based on a sliding scale matched to income.
10. Develop a comprehensive plan to build the capacity of seniors' centres across BC to better support social engagement and help support older people access the supports and services they need to continue to live independently.

LAST UPDATED

The content of this fact sheet is current as of March 27, 2023 as confirmed by Kiersten Fisher

APPROVALS

2023 03 31 – Peter Klotz obo Rob Byers, ADM, Finance and Corporate Services Division
2023 04 04 – Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

OSA 2023 Report on Home Support

Topic: Office the Seniors' Advocate 2023 Home Support report and recommendations.

Key Messaging and Recommended Response:

- **Health care workers have continued to ensure our family members are taken care of under challenging circumstances created by COVID. We know there is more work to be done to provide the supports our seniors need and to ensure staff are able to provide the best care possible.**
- **We know staffing is a challenge, which is why government has invested $585 million over 3 years to support the Health Careers Access Program (HCAP) to increase health care assistant staffing in LTC, AL and home support.**
- **As of February 1, 2023, 822 people have been hired through HCAP to work in home support across BC. We have also added a total of 270 new ongoing allied health seats to BC's public post-secondary institutions.**

CURRENT SITUATION

- On February 23rd, 2023, the Office of the Seniors' Advocate (OSA) released the report *We Must Do Better: Home Support Services for BC Seniors*.
- The report is an update of the OSA's 2019 report, *Home Support We Can Do Better*.

2023 Report Findings and Recommendations:

- Overall, the OSA found the majority of clients (87%) are satisfied with home support (HS) services and their service is an important part of being able to remain living at home.
- The OSA identified notable home support challenges and trends, including:
  - Services continue to be unaffordable for a large proportion of seniors;
  - Over the last 5 years, funding has increased by 42% and the community health worker (CHW) workforce has increased 25%, however clients served and hours delivered increased by 5.9% and 5.2%, respectively;
  - Service growth lags behind the 65+ aged target population growthv;
  - A large proportion of clients receive less than one hour of service per day; and yet, clients are becoming more complex and more caregivers are experiencing distress; and
  - 61% of seniors moving to long-term care had no HS 90 days prior to admission, and the rate of new residents who could be cared for at home is above the national average.
- Based on the findings, the OSA made five recommendations focused on: affordability, caregiver supports, flexibility and scope, and performance management. Three recommendations carry over from the 2019 report and two recommendations are new.
- Policy work underway in the Ministry to expand and improve home support services and meet growing population demand align well with the OSA's recommendations.

OSA Recommendation	Current Policy/Programs	Ministry Actions Underway
Eliminate the financial barrier to accessing home support (also recommended in the OSA's 2019 home support report and 2022 report on affordability).	Service cost is income tested and currently 65% of clients pay $0. Implementation of temporary policies so Federal/Provincial/Social Assistance COVID benefits do not increase client cost of HS service (i.e., CERB, BC Emergency Benefit) Temporary reduction of client rate for clients experiencing financial hardship.	Analysis of options to increase home support affordability is underway.
Increase respite care (also recommended in the 2019 home support report).	$145M committed over the last 5 years to expand respite services. 27,509 adult day spaces at 113 programs across BC as of December 31, 2022.[1]	Options to improve caregiver support, including respite care, are underway i.e., access and scope of adult day programs.
Standardize and set targets for all aspects of service delivery.	Care planning is unique to each client and identifies service levels to meet client need, taking into account health and functional status.	Work to set targets that guide home support service allocation is underway.
Modernize care plans: improve flexibility to meet changing client needs (also recommended in the 2019 home support report).	$140M since 2011/12 to expand the role of the community-based services sector to support seniors non-medical daily living needs and healthy aging. Additional $70M investment over 2 years beginning March 2023 **(NOT ANNOUNCED).** Temporary COVID response policies allow for more flexibility in providing assistance with daily living activities i.e., housekeeping and friendly visiting.	Policy is in development to modernize care plans, including introducing greater flexibility to perform non-medical tasks, improving client involvement in the care planning process, and bolstering the role/coordination of community-based services (e.g., Better at Home) with HA services.
Measure, monitor and report on performance.	Ministry monitors client and service data, including service levels, hours, and client counts. Repatriation of home support services in VCH, FH, and VIHA, enabled monitoring of all publicly subsidized services (where data from contracted services was not previously collected)	A performance monitoring framework focused on outcomes and overall system performance with key indicators and benchmarks is well underway.

- Home health modernization and strategic redesign to meet the needs of an increasing proportion of older adults in the population is well underway. Initiatives are designed to increase flexibility of service coverage in recognition of ongoing workforce shortages while also improving care coordination so clients can be supported to live at home longer in community.

FINANCIAL IMPLICATIONS

- Budget 2021 provides:
  - $68 million over 3 years of the fiscal plan ($22.5 million annually) to increase support for home care services, including increasing care aides and community providers.
  - $12 million over 3 years for the Home Health Monitoring Initiative which supports patients to self-manage their health from the comfort of their homes.
  - $585 million over 3 years to support the health career access program (HCAP).
- In 2021/22, HAs reported spending more than $1.9 billion on community care services, including adult day services, professional services (nursing and rehabilitation), home support, case management and assisted living services.
- The Ministry invested $145 million over the last 5 years to expand respite care and adult day programs, helping both seniors and their loved ones.

[1] ADP Re-opening Report, P9, 2022/23 with baseline data derived from P13, 2020/21

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- The COVID-19 pandemic had material impacts on home support budgets, staffing, and health authority ability to meet service demand while balancing client and worker safety. Despite these pressures, HAs were able to maintain and steadily increase service provision: [2]

	2019/20	2020/21	2021/22
Clients	52,600	51,100	53,900
Service Volumes (hours)	11,285,824	11,122,606	11,544,450

2019 Senior's Advocate Recommendations:

- The OSA's previous report on home support services, released on June 19th, 2019 titled *Home Support: We Can Do Better,* included seven recommendations to government focused on affordability, flexibility, scope, human resources, and caregiver supports:
    a. Remove financial barriers tied to the regulated daily rate co-payment – refresh allowable deductions to address inflation, retain the GIS exemption, and either extend the earned income rate cap to all remaining recipients, or adopt something similar to Fair Pharmacare
    b. Design an expansive and flexible care plan for use throughout the province that allows CHWs discretion to provide services on an as-needed basis to meet the changing needs of the client.
    c. Examine the role of Care Managers and determine if current resources are adequate to meet the need for greater management and coordination of services for home support clients.
    d. Embed support for family caregivers as a goal of care within the care plan, and provide a minimum of eight hours of respite per week if required.
    e. Produce a standardized document for clients and their family members that outlines the HS services they can expect to receive, the assessment process and the complaint process.
    f. Develop a program for client direct funding that is flexible and accessible.
    g. Improve working conditions for community health workers through the HAs working with HEABC to examine incentives to successfully recruit and retain CHWs. Incentives could include paid training, increased compensation, and stable part-time and full-time positions.
- Ministry staff reviewed the OSA's report and began work on policy development to address the recommendations, however, work was delayed due to health authority and Ministry priority on sustaining service through the COVID-19 pandemic.

LAST UPDATED

The content of this fact sheet is current as confirmed by Kiersten Fisher, ED, Seniors' Services Division.

APPROVALS

2023 04 12 - Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 04 14 - Peter Klotz obo Rob Byers, Finance and Corporate Services Division

[2] Ministry of Health. Report ID: 2391. Home and Community Care Services. Retrieved from: https://hspp.healthideas.gov.bc.ca/framework/service-delivery/specialized-community-services/home-and-community-care-services-report Last accessed on: 3/27/2023 10:52:46 AM

LEGISLATIVE SESSION – ESTIMATES NOTE

Palliative Care

Topic: Palliative and end-of-life care services are provided across the continuum of care, from acute care to home care and community hospice care, with the goal of improving the quality of life for people living with life limiting illnesses and supporting family caregivers.

Key Messaging and Recommended Response:

- **End of life and palliative care services are provided throughout the health care system, with the goal of supporting caregivers and improving the quality of life for those going through this most challenging of times.**
- **Our most recent Service Plan outlines our commitment to improve access and coordination of care for seniors with complex medical conditions and/or frailty including professional services, home support, caregiver supports, and palliative care with a focus on integration of services to enable individuals to remain living at home longer.**

CURRENT SITUATION

- Impact of the COVID-19 pandemic on palliative care in home and community care settings includes a trend toward later identification of clients, reflecting delay in some people seeking diagnosis and treatment.
- Throughout the pandemic, palliative care providers have shared clinical experience and resources related to end of life care, serious illness conversation, grief and bereavement.

Palliative Care and Hospice Beds

There are currently 482 palliative/hospice beds in British Columbia, including 328 community hospice beds (capturing both dedicated and designated community hospice beds) and 154 acute beds.[1,2] This represents an increase of 103 beds, or 27%, from March 2017. Currently, the provincial palliative care bed to population ratio is 11.0 hospice beds per 100,000 adults. International best practice is 8-10 beds per 100,000.[3] A higher ratio may reflect strategies to increase access to palliative care closer to home in rural communities, and/or regional variation in population characteristics such as age and complex chronic conditions/frailty.

Provincial Services/Initiatives

- The After-Hours Palliative Nursing Service (AHPNS), is a provincial telephone service that provides palliative nursing support to eligible clients living at home, and their caregivers, available in four regional health authorities (Interior Health Authority [IHA], Island Health Authority [VIHA], Northern Health Authority [NHA], and Fraser Health Authority [FHA]). Vancouver Coastal Health Authority (VCHA) maintains its own telephone-based service to support palliative clients and their caregivers. In 2021/22, the AHPNS managed 638 calls, and forwarded 98 calls to the Palliative Response Nurse upon being assessed as requiring more specialized support.[4]

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[1] HCC Long-Term Care & Assisted Living Summary Report, as of February 2023, HSIAR, BC Ministry of Health. **Dedicated end-of-life beds:* beds reserved for end-of-life care (and may not be used for anything else). *Designated end-of-life beds:* beds allocated for end-of-life care as of the survey date, but may at other times be allocated to different bed category..

[2] Acute Care Beds Report, as of 2022/23 P9, HSIAR, BC Ministry of Health.

[3] European Association for Palliative Care (2010). White Paper on standards and norms for hospice and palliative care in Europe: part 2. European Journal of Palliative Care, 17(1): 22-32.

[4] Email communication from HealthLink BC, received September 23, 2022.

[4] B.C. Guidelines, Palliative Care (Website). Available at: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/palliative-care

- BC Palliative Care Benefits (PCB) support BC residents of any age who have reached the end stage of a life-threatening illness to receive palliative care at home. Benefits include coverage for eligible palliative care medications, medical supplies and equipment. Over 162,000 clients have received PCB since its inception in 2001. In 2021/22, $21.2 million was spent on PCB medications and pharmacy.[5]
- *My Voice: Expressing My Wishes for the Future Health Care Treatment* (My Voice) is the BC Government's resource to assist the public with advance care planning. In 2022, the online My Voice guide was translated into an additional eight languages and is now available in English, French, Chinese, Punjabi, Korean, Farsi, Hindi, Vietnamese, Tagalog, Spanish and German.[6]

FINANCIAL IMPLICATIONS

- In 2022/23, the Federal government provided approximately $82 million to support home and community care in BC and of this, approximately 15.6% of the Federal funding is targeted to support palliative care.
- Government has provided $9.125 million to the Institute for Health System Transformation and Sustainability (IHSTS) between 2013-2015 to establish and support the BC Centre for Palliative Care (the Centre), of which $2.125 million was allocated to advance best practices in palliative care service delivery.
- In 2018/19, the Ministry provided $1 million (not yet announced but reported in Public Accounts), $2 million in 2019/20 (not yet announced but reported in Public Accounts), $1.5 million in 2020/21 (not yet announced but reported in Public Accounts) and $1.5 million in 2021/22 (not yet announced but reported in Public Accounts) to IHSTS in support of the Centre, to continue to improve access to palliative care, support implementation of provincial palliative care policy and partnership initiatives, education and local community-based initiatives.
- In 2018/19 and 2019/20, the Ministry provided $125,000 (not yet announced but reported in Public Accounts), $150,000 in 2020/21 (not yet announced but reported in Public Accounts) and $400,000 in 2021/22 (not yet announced but reported in Public Accounts) to Nidus Personal Planning Resource Centre Association to support the Advance Care Planning Program.

KEY BACKGROUND

- The 2023/24 to 2025/26 Ministry of Health Service Plan outlines government's commitment to improve access and coordination of care for seniors with complex medical conditions and/or frailty including professional services, home support, caregiver supports, and palliative care with a focus on affordability and integration of services to enable individuals to remain living at home longer.[7].
- The Province is also focused on linking a person-centred system of regional and provincial specialized services delivered by providers such as the Provincial Health Services Authority and BC Cancer, to support the full spectrum of cancer care including prevention, screening, diagnosis and treatment, research and education, as well as palliative care.[7]
- The Ministry supports palliative and end-of-life care services for people in the care setting that best meets their needs; and, a comprehensive and coordinated system of care that prioritizes the provision of palliative care at home and in community settings (hospice, assisted living, long-term care, and ambulatory care) where appropriate. Work underway in BC aligns with the 2019 Federal Action Plan on Palliative Care which lays out Health Canada's 5-year plan for palliative care in Canada and complements support provided to the provinces and territories under the Common Statement of Principles on Shared Health Priorities.[8]
- A palliative care incentive payment of $100.62 (G14063) compensates family physicians to take time needed to work through decisions and plans supporting quality of life for patients who are in the last 6 months of life expectancy, and their families (undertaking and documenting a care plan).[9]The Centre was established in

[5] Healthideas, Health Sector Information, Analysis and Reporting Division, Ministry of Health. March 21, 2023.
[6] Contract Issue Note, My Voice Translation, December 31, 2021, Seniors Services, BC Ministry of Health
[7]Ministry of Health (February 2023). *2023/24-2025/26 Service Plan*. Retrieved fromhttps://www.bcbudget.gov.bc.ca/2023/sp/pdf/ministry/hlth.pdf
[8] Government of Canada. (2019). *Action Plan on Palliative Care.* Retrieved from https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/palliative-care/action-plan-palliative-care.html
[9] 2022-02-04 GPSC Palliative Care Billing Guide (gpscbc.ca)

2013, by the IHSTS. The Centre is a provincial hub to advance the practice of palliative and end-of-life care for people living with and dying from serious illness.

LAST UPDATED

The content of this fact sheet is current as of April 14, 2023, as confirmed by Danielle Prpich, Executive Director, Seniors' Services Branch.

APPROVALS

2023 03 31 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 04 14 – Danielle Prpich, Seniors' Services Division
2023 04 20 – Peter Klotz obo Rob Byers, Finance and Corporate Services Division
2023 04 20 – Ross Hayward, Seniors Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

Potentially Inappropriate Use of Antipsychotics in Long-Term Care

Topic: The percentage of long-term care residents receiving antipsychotic medication without a diagnosis of psychosis has increased during the COVID-19 pandemic in BC and Canada.

Key Messaging and Recommended Response:

- **Our government remains committed to delivering the best quality of care to patients around the province, and a part of that is ensuring people receive appropriate care.**
- **The Office of the Seniors Advocate's 2022 Monitoring Seniors Services Report highlighted the potentially inappropriate use of antipsychotics is at its highest level in the past five years.**
- **At a national level, the use of antipsychotic medication in long-term care increased in 2020/21 and 2021/22 over pandemic period, including in BC.**
- **The increase is likely impacted by health system and health care challenges as a result of the pandemic and response measures, such as limited in-person visits for residents, as well as increased stress and workload due to pandemic protocols for residents and staff.**
- **Prior to the pandemic, the performance measure was gradually improving in BC (25.4% in 2017/18, 24.8% in 2018/19 and 24.7% in 2019/20).**
- **Adverse effects of antipsychotic medications can include sedation, and increased risk of falls, stroke and death in older persons.**
- **That is why we are continuing to take action to reduce the risks associated with inappropriate use of antipsychotics through initiatives like the PIECES Learning and Development program, which supports health care staff to assess and manage behavioural and psychological symptoms of dementia with interpersonal strategies.**
- **We're thankful for the role of the Seniors Advocate and the work they've done to illuminate issues and provide pathways to solutions. It helps us ensure that every senior in this province has access to the safe and quality services they deserve, which is something we value across government.**

LEGISLATIVE SESSION – ESTIMATES NOTE

CURRENT SITUATION

- Antipsychotics are sometimes used inappropriately to manage symptoms associated with dementia (including agitation and aggressive behaviours) among long-term care (LTC) residents. Inappropriate use of antipsychotic medication may negatively affect residents' quality of life.
- This performance measure has been included in the Ministry of Health's service plan since 2018/19. In 2017/18 The baseline measure was 25.4%.[1]
- The latest publicly-available data shows BC's percentage at 27.9% in 2021/22, 4% higher than the Canadian average of 23.9%.[1]
- The table below shows the service plan performance measure and trends in the actual percentages of potentially inappropriate use of antipsychotics in BC.

Ministry of Health Service Plan				**Actual Percentage (risk-adjusted)[2]**				
2017/18 Baseline	2023/24 Target	2024/25 Target	2025/26 Target	2019/20	2020/21	2021/22	2022/23	2022/23
Q1 – Q4	Q1-Q4	Q1-Q4	Q1-Q4	Q1 – Q4	Q1 – Q4	Q1 – Q4	Q1	Q2
25.4%	**25.0%**	**21.0%**	**18.0%**	**24.7%**	**26.5%**	**27.9%**	**28.1%**	**28.3%**

- Health authority quarterly data since 2020/21 shows performance is worsening in FHA and VCHA, stable in VIHA and IHA, and improving in NHA.

Potentially inappropriate use of antipsychotics by health authority (quarterly)[3]								
	2020/21		**2021/22**				**2022/23**	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
FHA	22.9%	23.6%	24.2%	25.1%	25.7%	26.3%	26.7%	26.6%
IHA	25.9%	26.3%	26.1%	26.2%	25.9%	25.7%	26.5%	27.0%
VIHA	27.2%	27.7%	27.9%	27.9%	27.6%	27.4%	27.1%	27.0%
NHA	40.6%	39.8%	38.6%	37.4%	35.2%	35.3%	34.2%	33.7%
VCHA	26.9%	27.8%	28.9%	29.8%	30.1%	30.9%	31.2%	31.7%
BC	**25.9%**	**26.5%**	**27.0%**	**27.5%**	**27.6%**	**27.9%**	**28.1%**	**28.3%**

- The Ministry has developed an action plan aimed at reducing the potentially inappropriate use of antipsychotics in LTC, Advice/Recommentations

Advice/Recommentations

FINANCIAL IMPLICATIONS

N/A

[1] CIHI Continuing Care Reporting System. Extracted 2023-02-01. Extracted 2023-02-01; Service Plan 2023/24 - 2025/26 Feb 2023. https://www.bcbudget.gov.bc.ca/2023/sp/pdf/ministry/hlth.pdf

[2] CIHI Continuing Care Reporting System. Extracted 2023-02-01

[3] CIHI Continuing Care Reporting System. Extracted 2023-02-01

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

- Adverse effects of antipsychotic medications can include sedation, and increased risk of falls, stroke, and death in older persons.
- The Canadian Institute for Health Information (CIHI) reports publicly on the potentially inappropriate use of antipsychotics as a quality indicator. CIHI also directly compares the provincial/territorial and national averages as an assessment of health service performance.
- The Office of the Seniors Advocate's 2022 Monitoring Seniors Services Report highlighted the potentially inappropriate use of antipsychotics is at its highest level in the past five years.[4]
- At a national level, the use of antipsychotic medication in LTC increased in 2020/21 and 2021/22 over pandemic period, including in BC. The increase is likely impacted by health system and health care challenges as a result of the pandemic and response measures, such as limited in-person visits for residents, increased stress and workload due to pandemic protocols for residents and staff.
- Prior to the pandemic, the performance measure was gradually improving in BC (25.4% in 2017/18, 24.8% in 2018/19 and 24.7% in 2019/20). [5]
- Provincial regulation governs the use of physical and chemical restraints in LTC settings.
- The PIECES Learning and Development Program™, which is an evidence-based approach for the care of people with dementia that health care providers apply in LTC settings. This program has been funded in BC since 2013, and funding has been extended until 2025.
- The CLeAR (Call for Less Antipsychotics in Residential Care) initiative, led by the BC Patient Safety and Quality Council (BCPSQC), was a quality improvement initiative aimed at LTC homes with high levels of potentially inappropriate antipsychotic use.
    - The BCPSQC website includes evaluation, lessons-learned, and resources related to CLeAR.
    - BCPSQC publishes practical resources, such as care plan templates, evidence based advice on prescription appropriateness, and resident assessment tools to support physicians and the care teams to assess options for non-pharmacological interventions and to help determine when antipsychotic use is appropriate.

LAST UPDATED

The content of this fact sheet is current as of April 11, 2023 as confirmed by Danielle Prpich.

APPROVALS

2023 03 09 – Christine Voggenreiter obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 04 24 - Ross Hayward, Seniors' Services Division

[4] Office of the Seniors Advocate (2022), Monitoring Seniors Services, 8th Edition
[5] CIHI Continuing Care Reporting System. Extracted 2023-02-01

LEGISLATIVE SESSION – ESTIMATES NOTE

Resident and Family Councils

Topic: Resident and Family Councils are an opportunity to ensure greater voices for residents and their families in decisions that affect them and their loved ones.

Key Messaging and Recommended Response:

- **Long-term care residences are people's homes and it's important that residents and family members have a place to share concerns and ideas when it comes to decisions about how the homes are operating.**
- **Resident and Family Councils ensure a greater voice for residents and their families, and strengthen the partnerships between residents, families, Long-Term Care home operators, health authorities and the Ministry of Health.**
- **In September 2022, the Residential Care Regulation (RCR) requirements were amended to enhance the role of Resident and Family Councils.**
- **In order to promote the intent for Resident and Family Councils to be independent and member driven, Long-Term Care (LTC) home operators only attend Resident and Family Council meetings by invitation from Council members.**
- **While the level of (LTC) home operator involvement is determined by Council members, the RCR requires LTC home operators to provide administrative support for Resident and Family Councils, such as providing a room for meeting and equipment to allow members to participate virtually.**
- **The RCR requires LTC home operators to, at least twice a year, provide the opportunity for Resident and Family Councils to meet with the LTC home operator for the purpose of promoting the collective interests of residents and involve them in decision making that affects resident's day-to-day experiences.**
- **The new RCR also requires LTC home operators to respond in writing to recommendations made by Resident and Family Councils.**

CURRENT SITUATION

- The Ministry of Health has taken steps to increase support for Resident and Family Councils (RFCs) in all licensed LTC homes, as announced by the Minister on November 3, 2022.
- In September 2022, the Residential Care Regulation (RCR) was amended to enhance the requirements related to RFCs in LTC homes.
- The Guideline for RFCs, *Developing, Supporting and Maintaining Resident Councils and Resident and Family Councils*, previously published in 2011, has been updated and published based on the new requirements.

- Each Health authority has established a Regional Resident Family Council and held at least one meeting (all complete as of March 31st). These meeting will provide an ongoing opportunity for RFC representatives to discuss successes, common issues of concern, share experiences and information to improve quality of life for residents of LTC homes.
- By June 30th, the Ministry will launch a new Provincial Committee that will hold an annual meeting with health authorities and Regional Councils to discuss systemic issues, promote best practices and advance quality of life for residents of LTC homes.

FINANCIAL IMPLICATIONS

To be determined.

KEY BACKGROUND

- RCR requirements were increased and improved to enhance the role of RFCs, ensuring a greater voice for residents and their families, and strengthening the partnerships between residents, families, LTC home operators, health authorities and the Ministry.
- In order to promote the intent for RFCs to be independent and member driven, LTC home operator only attend RFC meetings by invitation from Council members.
- While the level of LTC home operator involvement is determined by Council members, the RCR requires LTC home operators to provide administrative support for RFCs, such as providing a room for meeting and equipment to allow members to participate virtually.
- The RCR requires LTC home operators to, at least twice a year, provide the opportunity for RFCs to meet with the LTC home operator for the purpose of promoting the collective interests of residents and involve them in decision making that affects resident's day-to-day experiences.
- The new RCR also requires LTC home operators to respond in writing to recommendations made by RFCs.
- In April 2023, the Ministry received information for 300 publicly subsidized LTC homes, of which 276 (92%) had either a resident or family council (or a combination of both). 24 (8%) were found to have no resident or family council.

LAST UPDATED

The content of this fact sheet is current as of April 14, 2023.

APPROVALS

2023 04 12 - Danielle Prpich, Long Term Care & Assisted Living Strategy & Policy
2023 04 14 - Ross Hayward, Seniors' Services Division

LEGISLATIVE SESSION – ESTIMATES NOTE

2023/24 – 2025/26 Ministry of Health
Service Plan Measures and Year-to-Date Results

Topic: Outlining the eight *2023/24 – 2025/26 Ministry of Health Service Plan* performance measures, including forecast and targets, actuals and the year-to-date (YTD) results.

Key Messaging and Recommended Response:

- **The Ministry's Service Plan lists the government's priorities for the Ministry, its goals, objectives and performance measures. The annual report compares the goals with the actual results.**
- **We are proud of how far we've come in health care in BC. We recognize the challenges that the COVID-19 pandemic has set for us and continue to work towards the goals mentioned in the Minister's mandate letter.**
- **While there are challenges reaching some of these targets, for various reasons – we are seeing improvements in many of these measures, and our recent announcements on health human resources and recent labour agreements should help in getting there.**

CURRENT SITUATION

- The *2023/24 – 2025/26 Ministry of Health Service Plan* was tabled on Budget Day, February 28, 2023.
- The *2021/22 Ministry Annual Service Plan Report* was released alongside the Public Accounts on August 30, 2022.
- The Performance Measure tables below consist of:
  - Baseline (optional), Forecast and Target columns based on the *2023/24 – 2025/26 Ministry Service Plan;*
  - Actuals column based on the published *2021/22 Ministry Annual Service Plan Report*; and
  - The 2022/23 YTD columns are updated with available data at the time this estimates note was updated.
- The performance measures in the 2023/24 – 2025/26 Service Plan were updated to align with the new Crown Agency and Board Resourcing Office requirements which included performance measure changes:
  - The performance measures must now be aligned to goals (versus prior years where measures were aligned to each objective); and
  - Limit in place for the number of measures per goal to three measures per goal *where possible*.

FINANCIAL IMPLICATIONS

N/A

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

1a *Access to Primary Care Services – Number of Visits:* Tracks primary care visits across the province. This measure provides an indication of service levels and access to care for British Columbians.

2021/22 Actuals[1,2]	2022/23 Forecast[3]	2023/24 Target[3]	2022/23 YTD[4]
N/A	26,400,000	27,000,000	19,000,000

[1] NEW - introduced in 2023/24 MoH Service Plan.
[2] Data Source: BC Ministry of Health. Medical Services Plan.
[3] As published in the 2023/24 – 2025/26 Ministry of Health Service Plan.
[4] As of December 31, 2022. Results are reported on quarterly basis. Given 90-day billing window following date of service, data to December 31 may not be complete.

Discussion of YTD Results:
This indicator is on track to meet its 2022/23 forecast.

1b *Number of people admitted to hospital for a chronic disease per 100,000 people aged 75 years and older:* Tracks the number of people admitted to hospital for a chronic disease such as asthma, chronic obstructive pulmonary disease, heart disease or diabetes, per 100,000 people aged 75 years and older.

Baseline (2016/17)[1,2]	2021/22 Actuals[3]	2022/23 Forecast[4]	2023/24 Target[4]	2022/23 YTD[5]
3,360	2,164	2,110	2,700	2,110

[1] Introduced prior to 2012/13 MoH Service Plan.
[2] Data Source: Ministry of Health Discharge Abstract Database and P.E.O.P.L.E. 2022 (BC Stats)
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report. Based on 2021/22 Q3 annualized age-standardized rate and P.E.O.P.L.E. 2021.
[4] As published in the 2023/24 – 2025/26 Ministry of Health Service Plan, target is consistent with prior year service plan.
[5] Based on 2022/23 Q1 annualized age-standardized rate and P.E.O.P.L.E. 2022.

Discussion of YTD Results:
This indicator is continuing to exceed its 2022/23 target as forecasted. The target published in the 2022/23 – 2024/25 Service Plan was 2,750.

1c *Potentially inappropriate use of antipsychotics in long-term care*: Identifies the percent of long-term care residents who are prescribed antipsychotic medications without psychosis diagnosis. Antipsychotics are sometimes used to manage difficult behaviours associated with dementia when non-medication strategies are ineffective. Long-term care (LTC) homes are focused on improvement activities including reducing the use of antipsychotics.

Baseline (2017/18)[1,2]	2021/22 Actuals[3]	2022/23 Forecast[4]	2023/24 Target[4]	2022/23 YTD[5]
25.4%	27.7%	28.1%	25.0%	28.3%

[1] Introduced in 2019/20 MoH Service Plan.
[2] Data Source: Canadian Institute for Health Information Continuing Care Reporting System (CCRS)
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report. Based on 2021/22 Q3 annualized risk adjusted rate.
[4] As published in the 2023/24 – 2025/26 Ministry of Health Service Plan, target has been recalibrated to reflect reachable targets and to demonstrate incremental improvements.
[5] Based on 2022/23 Q2 data; results are annualized risk adjusted rates.

Discussion of YTD Results:
This indicator is not trending in the desired direction based on the target of 18% for 2022/23 as published in the 2022/23 – 2024/25 Service Plan. At a national level, the use of antipsychotic medication in LTC increased during the pandemic period, including in BC. The trend is likely impacted by COVID-19 response measures, including visitor restrictions, and health human resources challenges. Additionally, pandemic-related workload and staffing pressures have limited resources available to focus on quality improvement initiatives aimed at reducing antipsychotic use in LTC. Prior to the pandemic, the performance measure was gradually improving in BC (25.4% in 2017/18, 24.8% in 2018/19 and 24.7% in 2019/20).[1]

[1] CIHI Continuing Care Reporting System. Extracted 2023-02-01.

LEGISLATIVE SESSION – ESTIMATES NOTE

1d *Percentage of people admitted for mental illness and substance use who are readmitted within 30 days:* Focuses on effectiveness of community-based specialized services to help persons with mental illness and/or substance use issues receive appropriate and accessible care and avoid hospital readmission.

2021/22 Actuals[1,2,3]	2022/23 Forecast[4]	2023/24 Target[4]	2022/23 YTD[5]
15.3%	15.2%	13.8%	15.2%

[1] Introduced in 2015/16 MoH Service Plan.
[2] Data Source: Ministry of Heath Discharge Abstract Database
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report. Based on 2021/22 Q3 year to date data.
[4] As published in the 2023/24 – 2025/26 Ministry of Health Service Plan, target is consistent with prior year service plan.
[5] Based on 2022/23 Q1 data.

Discussion of YTD Results:
This indicator is not currently meeting target of 13.9% for 2022/23 as published in the 2022/23 – 2024/25 Service Plan, but is improving compared to the previous fiscal year.

2a *Ambulance In-Service hours:* Reflects the total available number of patient care hours provincially for ambulance services. This measure provides an indication of patient care service and system readiness.

2021/22 Actuals[1,2]	2022/23 Forecast[3]	2023/24 Target[3]	2022/23 YTD[4]
N/A	2,519,000	2,600,000	2,530,427

[1] NEW - introduced in 2023/24 MoH Service Plan.
[2] Data Source: BCEHS
[3] As published in the 2023/24 – 2024/26 Ministry of Health Service Plan.
[4] As of March 31, 2023. Results are reporting on quarterly.

Discussion of YTD Results:
The indicator met and exceeded the forecast for 2021/22.

2b *Total Operating Room Hours:* Reflects efforts to allocate surgical resources to increase access for surgical patients and catch up on surgeries lost due laregly to COVID-19.

Baseline (2016/17)[1,2]	2021/22 Actuals[3]	2022/23 Forecast[4]	2023/24 Target[4]	2022/23 YTD[5]
545,419	597,000	598,000	682,700	512,626

[1] Introduced in 2021/22 MoH Service Plan.
[2] Data Source: AnalysisWorks' Lighthouse.
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report. Based on 2021/22 Q3 year to date.
[4] As published in the 2023/24 – 2025/26 Ministry of Health Service Plan, target is consistent with prior year service plan.
[5] As of P11 (April 1, 2022 – February 2, 2023). Results are reported on by period.

Discussion of YTD Results:
This indicator is not achieving the target of 676,500 for 2022/23 as published in the 2022/23 – 2024/25 Service Plan due to on-going challenges to address urgent COVID-19 and Respiratory Illness needs.

3a *Nursing and allied professionals overtime hours as a percent of productive hours:* Compares overtime amounts to overall time worked by unionized professional nurses (Registered Nurses and Registered Practical Nurses) and allied professionals (occupational therapists, physiotherapists, medical techs, social workers, pharmacists, radiation techs). Overtime is commonly used as an indicator to assess aspects such as workload pressures.

2021 Actuals[1,2,3]	2022 Forecast[4]	2023 Target[4]	2022 Actuals YTD[5]
6.8%	8.1%	6.9%	7.9%

[1] Introduced in 2018/19 MoH Service Plan.
[2] Data Source: Health Sector Compensation Information System
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report.
[4] As published in the 2023/24 – 2025/26 Ministry of Health Service Plan, target has been recalibrated to reflect reachable targets and to demonstrate incremental improvements.
[5] Based on 2022 Q3 YTD data.

Discussion of YTD Results:
This indicator is not achieving the target of 3.8% for 2022 as published in the 2022/23 – 2024/25 Service Plan and is not trending in the desired direction.

3b *Percentage of population who access the provincial patient portal:* Tracks the number of British Columbians that access personal health records online. The Province is increasing access to personal health records for British Columbians through a digital portal. The portal empowers people to be active participants in their journey through BC's health system by providing them with secure and coordinated access to their personal health information, such as lab test results or prescribed medications, from anywhere.

2021/22 Actuals[1,2]	2022/23 Forecast[3]	2023/24 Target[3]	2022/23 YTD[4]
N/A	27%	40%	25%

[1] NEW - introduced in 2023/24 MoH Service Plan.
[2] Data Source: P.E.O.P.L.E. 2022 and Ministry of Health portal.
[3] As published in the 2023/24 – 2024/26 Ministry of Health Service Plan.
[4] As of January 31, 2023. Results are reported on quarterly.

Discussion of YTD Results:
This performance measure will provide an indication as the Ministry's ability to meet the public's demand for self-serve and digital options to access health information and services. Targets are set to reflect the number of people who have accessed the portal, or who have had someone access the portal on their behalf. The 2022/23 forecast reflects the anticipated number of users, 1.34M representing roughly 27 percent of BC's population. It is expected that the registered user base will gain steady growth year-over-year as the provincial health portal expands to provide users with a more comprehensive health record, access to more services, and the capability for people to access and manage health information on behalf of people who they support.

LAST UPDATED

The content of this fact sheet is current as of April 12, 2023, as confirmed by Vanessa Thomson.

APPROVALS

2023 03 10 - Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2022 03 16 - Ted Patterson, Primary Care Division
2022 03 19 - Jeff Aitken, Health Sector Information Management Information Technology Division
2022 04 06 - Ross Hayward, Seniors' Services Division
2022 04 12 - Kristy Anderson, Hospital and Provincial Health Services Division
2023 04 12 - Kelly Uyeno, Strategy Management and People Office

LEGISLATIVE SESSION – ESTIMATES NOTE

Ministry of Health Service Plan Performance Measures

Topic: Outlining the 4 performance measures previously included in the *2022/23 – 2024/25 Ministry of Health Service Plan*, and no longer included in the *2023/24 – 2025/26 Ministry of Health Service Plan*, including forecast and targets, year to date actuals.

Key Messaging and Recommended Response:

- **The Ministry's Service Plan lists the government's priorities for the Ministry, its goals, objectives and performance measures. The annual report compares the goals with the actual results.**
- **Every year, the Ministry reviews these measures and in some cases, will change them to a new performance measure that better indicates progress in meeting the needs of all people in this province.**
- **For example, we removed the measure of care hours per resident day in long term care. This measure was important when the Ombdusperson recommended 3.36 hours in 2012, it was aspirational, but since health authorities have well exceeded this goal for the last four years, it was time to adjust this measure.**

CURRENT SITUATION

- The *2023/24 – 2025/26 Ministry of Health Service Plan* was tabled on Budget Day, February 28, 2023.
- The performance measures in the 2023/24 Service Plan were updated to align with the new Crown Agency and Board Resourcing Office requirements which included performance measure changes:
  - The performance measures must now be aligned to goals (versus prior years where measures were aligned to each objective); and
  - Limit in place for the number of measures per goal to three measures per goal *where possible*.
- The removal of 4 measures from the current Service Plan reflects the Ministry's efforts to align measures that will best provide an indication of progress towards the current service plan goals.
- The 4 performance measures below were not included in the recently tabled Service Plan, however the Ministry can monitor results.
- The Performance Measure tables below consist of:
  - Baseline (optional), Forecast and Target columns based on the *2022/23 – 2024/25 Ministry Service Plan* which was tabled February 2022;
  - Actuals column based on the published *2021/22 Ministry Annual Service Plan Report* released in August 2022; and
  - The 2022/23 YTD columns are updated with available data at the time this estimates note was updated.

FINANCIAL IMPLICATIONS

N/A

LEGISLATIVE SESSION – ESTIMATES NOTE

KEY BACKGROUND

1.1 *Number of Primary Care Networks (PCNs) operating or in implementation:* Tracks cumulative implementation of PCNs across the province. The implementation of PCNs is part of comprehensive provincial strategy to transform the BC Health System.

Baseline (2016/17)[1,2]	2021/22 Actuals[3]	2021/22 Forecast[4]	2022/23 SP Target[4]	2022/23 YTD[5]
0	59	59	85	63

[1] Introduced in 2018/19 MoH Service Plan
[2] Data Source: BC Ministry of Health
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report.
[4] As published in the 2022/23 – 2024/25 Ministry of Health Service Plan.
[5] As of February 23, 2023. Results are reported on a monthly basis.

Discussion:
The PCN measure was replaced by Access to Primary Care Service - # of visits in this year's Service Plan. It was determined that measuring the increase in # of visits is a stronger indicator of services levels and access.

1.2a *Average direct care hours per resident day across all health authorities:* Tracks average direct care hours per resident day (HPRD) across all long-term care facilities in the province to improve and strengthen the quality of service and provide the best day-to-day assistance to seniors living in long-term care facilities.

Baseline (2016/17)[1,2]	2021/22 Actuals[3]	2021/22 Forecast[4]	2022/23 SP Target[4]	2022/23 YTD[5]
3.11	3.57	3.40	3.36	3.51

[1] Introduced in 2020/21 MoH Service Plan
[2] Data Source: Ministry of Health
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report
[4] As published in the 2022/23 – 2024/25 Ministry of Health Service Plan
[5] Forecast as of Q2 (September 30, 2022) based on resident days. Results are reported on quarterly.

Discussion:
The average direct care hours measure was removed from this year's Service Plan. The ministry has met or exceeded the target every year since 2020/21 and HPRD investments will be maintained to ensure funding to achieve the target of 3.36 HPRD, as a minimum, continues. Due to the new limits on the number of performance measures permitted in service plans the decision was made to remove this measure because targets were met.
When the incremental HPRD funding was announced in Budget 2018, government committed to fund each health authority to reach a target of 3.36 HPRD, on average, across all their long-term care homes by 2021. This target was achieved effective April 1, 2020. Effective April 1, 2022, the HPRD target goal was expanded and all long-term care homes across the province were funded to meet, at a minimum, the 3.36 HPRD target.

2.1 *Percent of communities that have completed healthy living strategic plans:* The measure focuses on the proportion of communities throughout the province that have developed healthy living strategic plans with their regional Health Authorities supporting collaborative planning and actions on agreed upon priorities. ("Communities" includes cities, districts, municipalities, towns, townships, and villages.)

Baseline (2017/18)[1,2]	2021/22 Actuals	2021/22 Forecast[4]	2022/23 SP Target[4]	2022/23 YTD[5]
63%	75%[3]	76%	78%	83%

[1] Introduced prior to 2012/13 MoH Service Plan
[2] Data Source: Health Authority annual community survey
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report.
[4] As published in the 2022/23 – 2024/25 Ministry of Health Service Plan
[5] Based on 2022/23 Q3 data.

Discussion:

- The percent of communities that have completed healthy living strategic plans measure was removed from this year's Service Plan. Due to updated focus of the Service Plan goals and the new limits on the number of performance measures permitted in the Service Plan this measure was removed. The Ministry will continue to work with health authorities and communities to advance the plans and to monitor progress.
- This performance measure focused on the proportion of the 160 communities in BC with healthy living strategic plans (HLSPs), developed in partnership with the ministry and health authorities.

2.2 *Rate of new C. difficile cases associated with a reporting facility per 10,000 inpatient days:* The measure monitors *C. difficile* infections in acute care facilities. Developing evidence-based prevention and control guidelines helps reduce such infections and improves quality of care and patient safety, protecting patients and healthcare providers.

Baseline (2017/18)[1,2]	2021/22 Actuals	2021/22 Forecast[4]	2022/23 SP Target[4]	2022/23 YTD[5]
3.8	3.0[3]	3.5	2.9	N/A

[1] Introduced in 2019/20 MoH Service Plan
[2] Data Source: Provincial Infection Control Network of BC (PICNet)
[3] As published in the 2021/22 Ministry of Health Annual Service Plan Report. Based on 2021/22 Q1 year to date data.
[4] As published in the 2022/23 – 2024/25 Ministry of Health Service Plan
[5] Data not available at this time.

Discussion:

- The rate of new C. difficile cases in an acute care facility was removed from this year's Service Plan. This performance measure results continues to be reported publicly by the Provincial Infection Control Network of BC on a quarterly basis The most current data available is for 2021/22 Q4. Because the ministry has exceeded or met targets, and due to the new limits on the number of performance measures permitted in the Service Plan this measure was removed.
- The C. difficile rate has consistently decreased (i.e., improving for patients) for the last 14 years. Over that time, there has been a substantial downward trend in the quarterly provincial rates of C. difficile infection in BC. Additionally, the measure's results demonstrate that health care facilities have strong infection and prevention control practices. The target for 2021/22 was exceeded due to ongoing monitoring, prevention, and control measures.

LAST UPDATED

The content of this fact sheet is current as of April 11, 2023, as confirmed by Vanessa Thomson.

APPROVALS

2023 03 09 - Maryna Korchagina, Population and Public Health Division
2023 03 10 - Eric Larson obo Martin Wright, Health Sector Information, Analysis & Reporting Division
2023 03 16 - Ted Patterson, Primary Care Division
2023 03 16 - Ross Hayward, Seniors' Services Division
2023 04 12 - Kelly Uyeno, Strategic Management and People Office