# Ministry of Health

# Estimates
# 2021



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# LEGISLATIVE SESSION - FACT SHEET

## Catastrophic Disaster Planning

### TOPIC

A 2014 Auditor General of BC audit on the state of Catastrophic Earthquake Preparedness in BC[1] highlighted the need for the Province to take action to ensure it is prepared to respond to a catastrophic earthquake event. The Ministry of Health (the Ministry), in cooperation with partner agencies, is taking steps to enhance the Provincial Government and the health system's ability to respond to a seismic disaster.

### CURRENT SITUATION

- In partnership with Health Emergency Management BC, the Ministry is undertaking a number of initiatives aimed at supporting the health system's ability to manage the impacts of a catastrophic event. This includes the active participation in, and support to, Emergency Management BC's provincial scale earthquake exercise (Coastal Response) that will occur in 2022.
- To address the likelihood of significant infrastructure disruption during a catastrophic event the Ministry of Health Emergency Management Unit is currently developing immediate action guidance and alternative coordination methods to ensure that provincial health system support can continue despite limitations.
- Health Emergency Management BC has undertaken work to improve the provincial health system's resilience to catastrophic events, including:
    1. Engaging with Lower Mainland Facilities Management as they conduct seismic assessments of health facilities.
    2. Partnering with Natural Resources Canada to model the impacts of several significant earthquake scenarios on health infrastructure based upon the Lower Mainland Facilities Management assessment. This information will be used to inform mitigation and planning activities.
    3. Developing a technical communications strategy to ensure alternate communications platforms are available to support emergency coordination following an earthquake.
    4. Formalizing a Mutual Aid Strategy to confirm how the BC health system will request and receive assistance from partners across Canada and the Pacific Northwest (e.g., Washington State) following an emergency.
    5. Working with Emergency Management BC and the Public Health Agency of Canada to develop a strategy for medical supply chain support following a catastrophic event.

### KEY FACTS

- In November 2017, the work of the Ministry of Citizens Services-led Critical Services Working Group was endorsed by the Deputy Ministers' Committee on Emergency Management.
- This work concluded that the Ministry of Health is responsible for 11 Catastrophic Response Actions (in the event a catastrophic event impacts the Province and provincial health system:
    1. Activate the Health Emergency Coordination Centre. The Health Emergency Coordination Centre is a function managed by the Ministry of Health Emergency Management Unit, which is constantly operational and scalable based on the size and nature of emergency incidents.
    2. Establish and lead the Health Branch at the Emergency Management BC Provincial Emergency Coordination Centre or Catastrophic Emergency Response and Recovery Centre. This role is fulfilled by the Provincial Health Duty Officer from the Emergency Management Unit.
    3. Identify available capacity across the health sector and, as necessary, coordinate the provision of personnel, equipment and medical supplies to impacted areas.
    4. Liaise with the Provincial Emergency Coordination Centre / Catastrophic Emergency Response and Recovery Centre to arrange medical evacuation out of impacted areas.
    5. Coordinate the provision of additional medical teams to impacted areas.
    6. Coordinate the implementation of Disaster Recovery Plans of key clinical systems.

[1] BC Government, Auditor General. Catastrophic Earthquake Preparedness 2014. https://www.bcauditor.com/sites/default/files/publications/2014/report_15/report/OAG%20Catastrophic%20Earthquake_FINAL.pdf

7. Provide public non-emergency health information and advice through existing TeleHealth and Web Services.
8. Coordinate any national or international medical assets deployed to BC.
9. Identify capacity across the health sector to support community health.
10. Assist in coordinating the provision of mental health and disaster psychosocial services.
11. Perform rapid public health risk assessments, surveillance and data collection in order to provide appropriate public health messaging.

- The Ministry of Health continued to work with the Critical Services Working Group to identify facilities, human, and information management/information technology resources required to support its Catastrophic Response Actions, and by December 2018, the Ministry submitted an approved list of resources anticipated to be required to support the Ministry in meeting its CRA responsibilities.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
January 25, 2021 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Outbreaks

## TOPIC

COVID-19 outbreak data is reported daily, Monday to Friday, to the Minister of Health and the Provincial Health Officer. The daily outbreak report data contains information on the number of outbreaks, the health authority region of the outbreak, the facility or location of the outbreak, the number of cases connected to each outbreak, and the number of deaths connected to each outbreak.

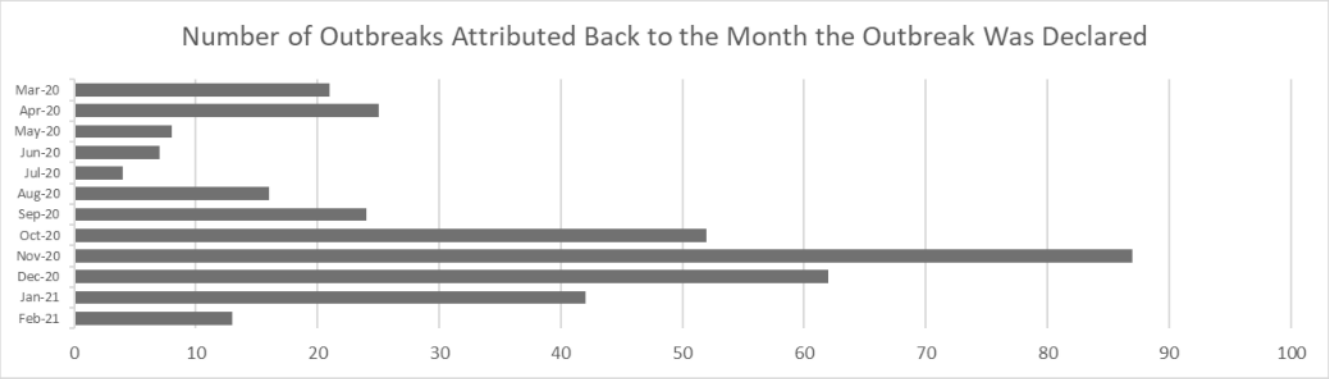
## CURRENT SITUATION

As of February 16, 2021, roughly 10 % of all COVID-19 cases in British Columbia have been outbreak-connected (7,190 cases out of a total of 74,710 cases). However, most COVID-19 deaths, 71%, have been connected to outbreaks (936 deaths out of a total of 1,317 deaths).

## KEY FACTS

How many outbreaks?

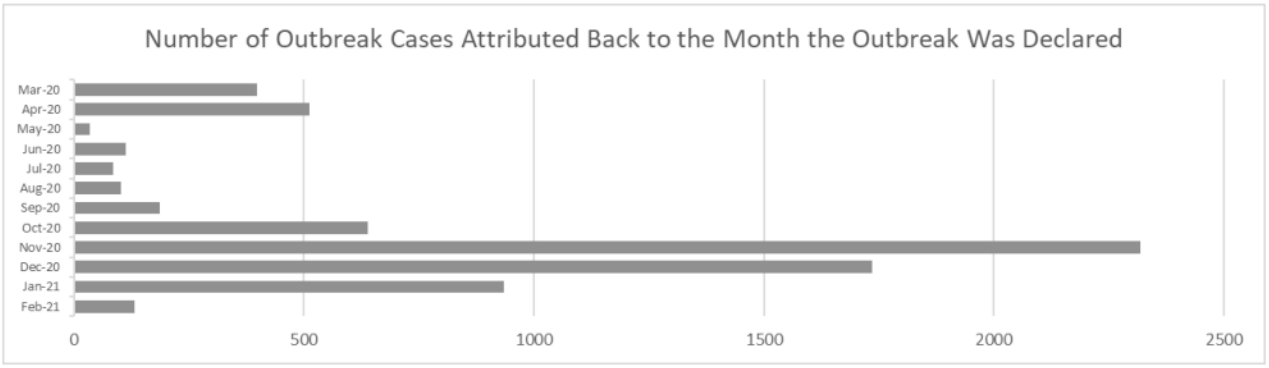
- As of February 16, 2021, there have been a total of 361 COVID-19 outbreaks in British Columbia.
- 82% (297 outbreaks) have been in health and community care settings: Acute Care (71 outbreaks), Long Term Care (189 outbreaks), Assisted Living (23 outbreaks) and Independent Living (14 outbreaks).
- 11% of the remaining outbreaks (38 outbreaks) have been in workplaces.
- The remaining 7% (26 outbreaks) have been in correctional facilities (6 outbreaks), schools and daycares (5 outbreaks), shelters (4 outbreaks), group homes (4 outbreaks), 2 hospitality, 1 athletic organization, 1 dance school, 1 conference, 1 religious institution and Canim Lake.




How many outbreak-connected cases?

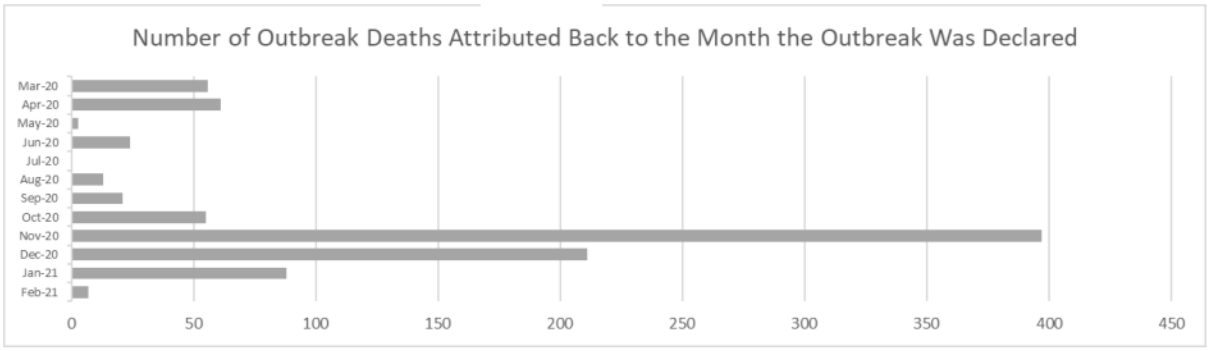
- As of February 16, 2021, there have been a total of 7,190 COVID-19 cases connected with outbreaks.
- Within Acute Care, Long Term Care, Assisted Living and Independent Living facilities, most cases have been residents (3,302) but many cases (2,183) have been staff. There has been a total of 5,485 cases in these facilities.
- There have been 809 cases connected to workplace outbreaks.
- There have been 896 cases connected to the remaining outbreaks.

# LEGISLATIVE SESSION - FACT SHEET




How many outbreak-connected deaths?

- As of February 16, 2021, there have been a total of 936 COVID-19 deaths in outbreaks in BC.
- Almost all outbreak-connected deaths have been residents in health and community care settings: Acute Care (157 deaths), Long Term Care (754 deaths), Assisted Living (17 deaths), and Independent Living (5 deaths). There has been no outbreak connected deaths among staff at these settings.
- The remaining 3 outbreak-connected deaths were at Canim Lake's outbreak Personal Information the Mission Medium Institution Correctional Facility outbreak Personal Information and the Westsyde Care Residence group home Personal Information




## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 19, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Emergency Management BC Provincial Supply Hub

### TOPIC

The Emergency Management BC (EMBC) Provincial Supply Hub (Supply Hub) is an online platform to provide a single point of access to purchase Personal Protective Equipment (PPE) and critical supplies during the COVID-19 pandemic for the non-health, public and social service sectors.

### CURRENT SITUATION

- Launched in July 2020, the Supply Hub allows eligible organizations to purchase PPE and critical supplies. Eligible organizations include:
  - First responders (such as fire departments and police services);
  - Local governments;
  - Federal government and all provincial and territorial governments;
  - First Nation governments and Indigenous organizations;
  - Entities in the Government Reporting Entity, as defined in the *Budget Transparency and Accountability Act (*such as Community Living BC and BC Sheriff Services); and
  - Broader public sector and other entities, including public and private social service providers.
- The supplies available for purchase on the Supply Hub include gloves, gowns, face shields, cleaner, hand sanitizer, masks, and wipes.

### KEY FACTS

- In December 2020, government approved EMBC to wind down the Supply Hub and to sell as much product as possible before September 2021.
- In March 2021, given the Supply Hub's substantial inventory, an option for bulk order and discounts was announced to customers.
- The bulk sales approach reduced the sale price to the customer, offering pallet discount prices on Supply Hub PPE and critical supplies.
- Purchases made by the pallet were sold for between 15% and 54% discount depending on the product.

Background

- In March 2020, the BC health sector began increasing its efforts to secure access to PPE and critical supplies that were in short supply globally due to the COVID 19 pandemic.
- In July 2020, the Province approved the purchase and distribution of PPE and critical supplies for the social services sector and public sector entities. An agreement to this effect was entered into on July 31, 2020 with the Ministry of Citizens Services, EMBC and the Provincial Health Services Authority. On August 6, 2020, the province launched the Supply Hub, to sell non health PPE and critical supplies to the non-health sector, public and social services sectors.
- As part of the agreement, EMBC has the ability to distribute both purchased and donated non health PPE and critical supplies to the non health public sector and social services sector.

### FINANCIAL IMPLICATIONS

N/A

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**Approved:**

May 31, 2021 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division

June 3, 2021 – Peter Pokorny, Associate Deputy Minister, Corporate Services

# LEGISLATIVE SESSION - FACT SHEET

# Health Emergency Management (Provincial)

## TOPIC

The provincial health system has a comprehensive health emergency management program in place to increase its ability to prepare for, respond to, and recover from a variety of natural and public health hazards, such as earthquakes, wildfires, environmental accidents and infectious disease threats.

## CURRENT SITUATION

- On March 17, 2020, the Provincial Health Officer declared a Public Health Emergency under the *Public Health Act* in response to the COVID-19 pandemic.
- From March 11, 2020 to May 28, 2020, the Ministry of Health (MoH) activated its Health Emergency Coordination Centre (HECC) to a Level 3 in response to the COVID-19 pandemic. During this same period regional health authorities activated their Emergency Operations Centres.
- The COVID Response and Health Emergency Management Division was created on May 28, 2020, to coordinate the ongoing health system response to the pandemic. In parallel, health authorities have identified Vice-Presidents of Pandemic Response to lead regional efforts in coordination with the MoH and other partners.
- In support of the potential need to evacuate individuals and communities due to natural hazards and other events, the MoH's Emergency Management Unit (EMU) has been working closely with partner agencies to update and develop Evacuation Guidelines and notification processes to include COVID-19 considerations.
- The EMU and Health Emergency Management BC (HEMBC) continue to support the health system as it responds to the COVID-19 pandemic by supporting the vaccination activities of the Immunize BC Operations Centre.
- A complete rebuild of the business continuity management program is currently underway for the MoH and the Ministry of Mental Health and Addiction. For more information, please refer to Fact Sheet *Ministry of Health Business Continuity Program*.

## KEY FACTS

- The federal *Emergency Management Act* requires all federal, provincial and territorial governments in Canada to have comprehensive emergency management plans respecting preparation for, response to, and recovery from emergencies.
- The provincial *Emergency Program Management Regulation* assigns responsibility to the Minister of Health for coordinating the government response to diseases and epidemics and incidents involving hazardous materials.
- Chapter 16 of the Core Policy and Procedures Manual mandates the development and maintenance of business continuity plans by the whole of government.
- BC's *Public Health Act* provides a legal basis for the Provincial Health Officer and Medical Health Officers to enact orders and other measures in response to a public health emergency.
- Public Health Emergency Management is Goal 7 of BC's Guiding Framework for Public Health. This goal includes maintaining preparedness to respond to pandemic events.
- The EMU works collaboratively with the First Nations Health Authority, the Provincial Health Services Authority (PHSA), regional health authorities, and BC Emergency Health Services to set strategic and operational direction across the provincial health system, and within the health emergency management profession.
- EMU staff lead the development and maintenance of provincial health emergency plans such as the development of the BC Nuclear Emergency Response Plan and the BC Wildfire Smoke Response Coordination Guidelines. In addition to leading provincial health system planning, EMU staff promote the health system's participation in provincial emergency exercises.
- The EMU works closely with Emergency Management BC, ministry partners, federal organizations (Public Health Agency of Canada, Health Canada, Public Safety Canada, Department of National Defence), and neighbouring jurisdictions (e.g. Alberta) to coordinate and communicate emergency response activities.

- The EMU is responsible for ensuring that MoH Business Continuity Plans are compliant and exercised in accordance with Chapter 16 of the Core Policy and Procedures Manual to prepare for the effective recovery of functions and services critical to the MoH, and to ensure the delivery of quality patient care across the province.
- The EMU maintains the HECC, which includes a 24/7 Provincial Health Duty Officer function and a scalable emergency response capacity based on the Incident Command System. The EMU provides training to MoH executive and staff to prepare them for deployment to the HECC when additional support is required.
- The EMU Director actively participates in a range of Federal/Provincial/ Territorial initiatives including developing an updated Public Health Response Plan for Biological Events (e.g. pandemic influenza) and implementing a plan for the cooperative management of patients with a serious, highly infectious diseases.
- In 2015, the EMU integrated with HEMBC. HEMBC is a program of the PHSA that provides emergency management leadership and support to the BC health system.
- HEMBC staff work across all health authorities to ensure the provincial health system can effectively plan for, respond to, and recover from emergency events. This work includes the development and implementation of strategic and operational emergency management plans and programs at all levels of the health system.
- HEMBC works with partner organizations to conduct site, regional, and provincial level emergency exercises and emergency management functional training programs across BC. For example, in April 2019 more than 450 heath care staff across Lower Mainland Hospitals and sites exercised a Code Orange (mass casualty) response to a major plane crash at the Vancouver International Airport.
- HEMBC training is currently being standardized across all regional health authorities to improve transferability of skillsets and tracking of competencies.
- HEMBC is responsible for the provincial Disaster Psychosocial Program, which provides post-disaster emotional and psychological support to impacted communities. The program comprises over 200 trained volunteers and has been deployed to a range of events in BC and Alberta. In response to the provincial overdose crisis, the Disaster Psychosocial Program created a Mobile Response Team to provide psychosocial support to impacted front line workers, emergency responders, volunteers, and staff from community-based organizations.
- In July 2019, HEMBC accepted responsibility for the Mobile Medical Unit (MMU). The MMU is a mobile health facility and is owned by the PHSA as a service of HEMBC, and partners with all BC's health authorities. The MMU is an extension of all hospitals and health centres in BC, which means that a host facility's clinicians are accredited to work in the space and their own procedures and protocols are in effect during the deployment. The MMU provides surge support for disaster events, business continuity impacts, and as a clinical and mobile health consultation service.
- The HEMBC Disaster Psychosocial Services Program leads the development of disaster psychosocial programs within BC and provides psychosocial services upon request and with the agreement of the impacted community. HEMBC staff continue to work closely with partners to support mental health recovery in disaster affected communities.
- In both 2017 and 2018, BC declared a Provincial State of Emergency to support the provincial response to seasonal wildfire events. At that time, the MoH also activated its HECC to a Level 3 and several regional health authorities activated their Emergency Operation Centres.
- The Chapman-Abbott Report was an independent review of the 2017 flood and wildfire season. The report identified 108 recommendations, five of which directly targeted the health system. All health system recommendations have either been completed or are currently being addressed.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
January 25, 2021 - Ian Rongve, Assistant Deputy Minister, COVID Response Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Sector Pandemic Influenza Preparedness

### TOPIC

- The BC Pandemic Influenza Response Plan (The Plan) was released in 2012, building on the 2009 H1N1 Pandemic Influenza Response Plan and on the lessons learned from that pandemic.
- The Plan is comprised of 16 distinct guidance documents and complimented by the BC Pandemic Influenza Provincial Coordination Plan.

### CURRENT SITUATION

- Elements of The Plan have informed the ongoing provincial response to the COVID-19 pandemic.
- In February 2020, led by Emergency Management BC, the BC Pandemic Influenza Provincial Coordination Plan was updated to support an all of government response to the COVID-19 pandemic and is now called the BC Pandemic Provincial Coordination Plan.

### KEY FACTS

- The Plan addresses key health system areas of preparedness and response, including:
  - Planning assumptions to help guide pandemic planning efforts;
  - Public health guidance for laboratories, surveillance, antiviral distribution, vaccine storage, distribution and security, and public health measures;
  - A provincial ethics framework;
  - Acute care guidelines and tool kit;
  - Infection control guidelines;
  - Human resources;
  - Communications and education;
  - Psychosocial plans for health care workers and the public; and
  - Considerations for First Nations and remote communities.
- The Plan is web-based to enhance accessibility and navigation and enable updates to be posted as required.
- The Plan has a general pandemic view and is intended to be re-focused in the event of a newly declared pandemic to provide specific information on the emerging pathogen.
- In addition to The Plan, the Ministry of Health worked jointly with Emergency Management BC and the Ministry of Transportation and Infrastructure to develop the BC Pandemic Influenza Provincial Coordination Plan. This document was completed in January 2015 and is included as a hazard specific annex of the BC Comprehensive Emergency Management Plan.
- The BC Pandemic Influenza Provincial Coordination Plan describes the Province's strategy for cross-ministry coordination, internal and external communications and provincial government business continuity during a pandemic influenza event.
- While the *Emergency Program Management Regulations* identify the Ministry of Health as the lead agency for human diseases, the BC Pandemic Provincial Coordination Plan further identifies the Office of the Provincial Health Officer as responsible for providing leadership and guidance to pandemic preparedness activities across the health sector.
- The provincial and local government legal authority to plan and respond to the health consequences of a pandemic event reside within the *Public Health Act* and the *Community Charter*, *Public Health Bylaws Regulation*.

### FINANCIAL IMPLICATIONS

N/A

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**Approved:**
January 19, 2021 - Ian Rongve, Assistant Deputy Minister, COVID Response and Health Emergency Management

# LEGISLATIVE SESSION - FACT SHEET

## Ministry of Health Business Continuity Management Program

### TOPIC

- The Business Continuity Management Program (BCMP) is designed to ensure that critical services and priority programs provided by the Ministry of Health will continue to be delivered at a high quality to British Columbians and health system partners in the event of a disruption.
- Following an annual cross government review cycle, the BCMP oversees the Ministry's Business Continuity Plans (BCPs) which focus on the resumption and maintenance of critical services until a return to a pre-determined level of operation is possible, with prioritized functions based on a business impact analysis.

### CURRENT SITUATION

- In October 2019, the Internal Audit and Advisory Services undertook an audit of the Ministry's BCP as part of an overall government BCP assessment; the findings will be publicly reported in 2021.
- In parallel to the Internal Audit and Advisory Services audit, and in preparation for a response to the findings, the Ministry's Emergency Management Unit (EMU) conducted a gap analysis of the Ministry's BCMP
- The EMU developed a modernization strategy to rebuild the ministry BCMP and address issues identified through both the audit and gap analysis, which is now being implemented.

### KEY FACTS

- In March 2006, the EMU initiated the development of a comprehensive BCP, in compliance with Chapter 16 of the *Core Policy and Procedures Manual*.[1]
- Adherence to the *Core Policy and Procedures Manual* helps to ensure the BCPs are consistent across all BC Government ministries and are compliant with Emergency Management BC and Government Security Office business continuity standards and guidelines. This approach is consistent with, and supported by, the Province's Business Continuity Management Advisory Committee, within which the Ministry is an active participant.
- The EMU's BCP Advisor (a dedicated Emergency Management function) provides leadership to the Ministry BCP Committee in order to facilitate the internal Business Continuity Management program. Committee representatives (BCP coordinators) are delegated to steward business continuity planning in their program area.
- The objectives of the Ministry's BCMP include:
    - Providing mechanisms to ensure that all program areas are aware of business continuity policy and procedure requirements;
    - Comprehensively defining and understanding the full scope of business activities within each program area;
    - Developing practical, relevant and applicable BCPs for each program area to respond to an event that impacts Ministry buildings, resources, and operations;
    - Ongoing evaluation and validation of BCPs and procedures, and the reporting of business continuity progress and status; and
    - Exercising business continuity plans with staff at all levels.
- The key deliverables of the Ministry's BCMP include:
    - Risk Assessments to identify, analyze and evaluate risks at all locations housing Ministry staff.
    - Business Impact Analyses to identify critical business functions and supporting resources.
    - Business Continuity Plans to document approved procedures, strategies and arrangements to ensure the continuity of critical services.
    - Conducting After Action Reports to document exercise outcomes and identify actions to support continuous improvement.

[1] BC Government. Core Policy and Procedures Manual: Policy Chapter Summaries (Chapter 16). https://www2.gov.bc.ca/gov/content/governments/policies-for-government/core-policy/policies/business-continuity-management . Last accessed September 3, 2020

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

January 26, 2021 - Ian Rongve, Assistant Deputy Minister, COVID Response and Health Emergency Management Division
January 30, 2021 - Philip Twyford, Assistant Deputy Minister, Finance and Corporate Services

# LEGISLATIVE SESSION - FACT SHEET

## Personal Protective Equipment and Critical Supplies for General Practitioners, Physician Specialists and Nurse Practitioners

### ISSUE

Access to Personal Protective Equipment (PPE) and critical supplies for general practitioners, nurse practitioners and physician specialists to continue to support primary care services in community during the remainder of the COVID-19 pandemic.

### CURRENT SITUATION

- Entering fall/winter 2020, there were concerns that the COVID-19 pandemic would continue to disrupt global supply chains for medical grade PPE and critical supplies.
- As general practitioners, nurse practitioners and physician specialists continue to support routine and COVID-19 related care in community settings and keep patients out of acute care settings, it is critical that they have access to PPE and critical supplies.

### KEY FACTS

- In the first wave of the pandemic and over the summer months, the regional health authorities assisted community providers with PPE and critical supplies.
- To ensure these supplies continue to flow over the remainder of the COVID-19 pandemic, the Ministry of Health, Provincial Health Services Authority and the Ministry of Citizens Services (CITZ) implemented a province-wide web-based solution, the Health PPE Portal, to allocate and distribute supplies. Items are provided at no charge to eligible care providers for the remainder of the pandemic.
- The provincial site was launched on November 30, 2020 and was rolled out incrementally to providers by regional health authority. Fraser Health Authority and Vancouver Coastal Health Authority were prioritized for initial access to the supplies followed by the remaining health authorities in the weeks after.
- Community health-care providers that billed the *Medical Services Plan* over the 14 months preceding the launch are eligible for the supplies and received information in November as to when and how to access the ordering system. In March 2021, practitioners received additional communication informing them the second allocation of PPE and critical supplies was available to order. As we enter a new 3-month period in June 2021, eligible practitioners will be receiving information for the next allocation period.
- Supplies include medical-grade procedure masks, gowns, gloves, eye protection, and disinfectant products.
- Through this system, health-care providers are able to order up to 3 months of supplies needed to support increased in-person visits. The maximum amount that can be ordered was developed in consultation with the Doctors of BC, Provincial Health Services Authority and regional health authorities.
- CITZ is responsible for client services and providing information about the new online ordering system.
- CITZ forwards any requests for additional PPE to the Ministry. The Ministry has a process in place to review and approve additional supplies. There have been constraints on some supplies, such as N95 respirators and nitrile gloves, based on provincial availability over the last year. The province moved from Stage 5 to Stage 1 under the PPE allocation framework: COVID-19: Emergency Prioritization in a Pandemic Personal Protective Equipment (PPE) Allocation Framework[1] in May 2021, which has eased the constraints around most supplies.
- CITZ stores and packages the PPE and critical supplies at their distribution centre and ships supplies through Purolator and Canada Post. It is expected orders from the province-wide web-based system are shipped within 5 business days.
- As of May 27, 2021approximately 5,000 practitioners have accessed the portal. They have received 5,035,350 procedure masks, 237,740 pieces of eye protection, 3,731,900 pairs of gloves, 427,760 gowns, 122,180 N95 respirators and 354,482 packages of wipes and tubes of hand sanitizers.

[1] http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_ppe_allocation_framework.pdf

# LEGISLATIVE SESSION - FACT SHEET

Background

- In March 2020, during the initial onset of the COVID-19 pandemic, the global supply chain for PPE and critical supplies became significantly disrupted, with a simultaneous increase in both demand and cost.
- In addition, global markets experienced and continue to face substantial cost increases for PPE and critical supplies provided by long-term reliable contractors and new/alternative suppliers.
- When the pandemic arrived in BC in March 2020, community primary care providers who were unable to access PPE and critical supplies through their regular vendors were provided supplies without charge by health authorities as an emergency measure.
- Supply and distribution of PPE and critical supplies to general practitioners, nurse practitioners and community specialists was difficult to establish and was not standardized across health authorities. Health authorities previously were responsible for the cost of the supplies provided to community care providers.

## FINANCIAL IMPLICATIONS

Government Financial Information

- PPE and critical supplies that will be distributed to primary care community providers have either been donated by the Federal Government or purchased by the Provincial Health Services Authority as part of the provincial supply.

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**Approved:**
May 31, 2020 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division
June 3, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Personal Protective Equipment Green Initiatives

### TOPIC

Green initiatives and projects underway to address concerns of Personal Protective Equipment (PPE) waste resulting from the COVID-19 pandemic.

### CURRENT SITUATION

- An unprecedented amount of PPE to prevent transmission of COVID-19 is being used in Canada by frontline health care workers, non-healthcare workers and the general population.
- The surge in demand and use of PPE has led to a significant increase in the levels of PPE waste across the country. Based on recent federal government projections for PPE demand over the next year, it is estimated that approximately 63,000 tonnes of COVID-19-related PPE will accumulate as waste by mid-2021.[1]
- Most single-use PPE, considered non-hazardous waste, is collected as part of the regular waste stream and is sent to landfill. Provincial and territorial governments are responsible for establishing requirements for the disposal of hazardous and bio-hazardous materials and waste.
- In response to unprecedented use of PPE, the Ministry of Health, in partnership with the Provincial Health Services Authority and the regional health authorities are undertaking a number of green initiatives as they relate to PPE waste.
- PPE green initiatives underway include:
    - On March 29, 2020, the Ministry operationalized the Emergency Prioritization in a Pandemic: Personal Protective Equipment Allocation Framework which included direction to all health care workers to conserve PPE by extending the use of masks, respirators, and eye protection to one per shift, changing only when absolutely necessary.[2] This direction continues with the implementation of stage 1 of the Framework.
    - The BC Centre for Disease Control has published guidance for cleaning and disinfection for eye and facial protection[3] for extending the use of these products.
    - The use of reusable elastomeric respirators in the regional health authorities has resulted in an estimated 223,336 respirators saved[4] since the start of the pandemic. This practice is ongoing.
    - BC Emergency Health Services has completed a full deployment of reusable elastomeric respirators to approximately 4,000 paramedics province wide.[5]
    - From April 2020 to 2021, the Ministry implemented a temporary directive for all health-care facilities to collect used N95s that were not soiled or damaged for reprocessing for contingency supply.[6]
- In March 2020, Ministry established the Health Sector Pandemic PPE Recycling Working Group, consisting of representative and specialists from Provincial Health Services Authority, regional health authorities and the Ministry. This Working Group is developing a business case to pilot a hospital-based PPE recycling program with the option to expand provincially.
- PPE Hospital Based Recycling Pilot Project:
    - By working with the private sector, the working group is exploring opportunities to locally recycle PPE containing polypropylene into a product that can be used to create long-term plastic products that are not single use.
    - Vitacore, a Burnaby based PPE manufacturing company, has conducted a pilot project for recycling PPE at four Urgent Primary Care Centre's in the lower mainland. Vitacore is consulting with the Working Group to share the results of this pilot experience.

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[1] Reducing the Environmental Impacts of PPE Waste, Health Canada and Environment and Climate Change Canada
[2] BCCDC Personal Protective Equipment (PPE) Bulletin #1, March 29, 2020: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_PPEBulletin1.pdf
[3] http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_EyeFacialProtectionDisinfection.pdf
[4] Provincial N95-PPE Sub Working Group Report, March 18, 2021
[5] Email communication from BCEHS Mike Michalko, October 19, 2020
[6] BCCDC Personal Protective Equipment (PPE) Bulletin #2, April 8, 2020: http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_PPEBulletin2.pdf

- Following the conclusion of the hospital-based pilot project, the recycling partner(s) for an ongoing provincial program will be selected through a Request for Proposal (RFP) process hosted on BCBid.

## KEY FACTS

- In 2018, the Province launched the CleanBC climate action plan. The Ministry is mandated the responsibility of working to achieve CleanBC's goals, including reducing waste and turning it into a clean resource.
- The green initiatives undertaken by the Ministry and the health authorities have reduced the amount of PPE waste reaching landfills through extending the use of PPE where it is safe to do so, the use of reusable respirators where appropriate, and reprocessing respirators to have on hand for contingency purposes in the event that supply is constrained in the future.
- The PPE recycling pilot project will contribute to a PPE circular economy which allows for the maximum extraction of the value of an item or resource (such as plastics) before being carefully reinvented, regenerated or recycled at end of life.

## FINANCIAL IMPLICATIONS

The total costs related the project will be determined as part of the business case development.

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**Approved:**
May 21, 2021 – Ian Rongve, Assistant Deputy Minister, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Personal Protective Equipment Inventory Reconciliation

### TOPIC

Personal protective equipment (PPE) and critical supplies: cumulative and health grade inventory on hand and issued between March 2020 and May 25, 2021.

### CURRENT SITUATION

- The table below shows: Cumulative Total PPE inventory [Category 1, 2, 3 and 4 under the *BC Centre for Disease Control/Ministry of Health, BC Personal Protective Equipment Supply, Assessment, Testing and Distribution Protocol]* that was last publicly announced by the Minister of Health on January 18, 2021; the May 25, 2021 cumulative totals; and, the increase in these amounts since January 18, 2021.

**TABLE 1: CUMULATIVE INVENTORY**

| Item | Cumulative Total PPE January 18, 2021 | Cumulative Total PPE May 25, 2021 | Increase Jan 18 to May 25, 2021 |
|---|---|---|---|
| Respirators | Just over 8,200,000 | Government Financial Information | |
| Masks (Surgical / Procedure) | Almost 143,500,000 | | |
| Gloves (pairs) | Just over 330,000,000 | | |
| Gowns | Almost 19,000,000 | | |
| Eye Protection | Just over 3,100,000 | | |
| **Total Items** | **503,800,000** | | |

- The following table shows: Total Category 1 and 2 inventory (quality assured for health care use) currently held by the Provincial Health Services Authority and the regional health authorities; Days on Hand; and, Products Issued between March 1, 2020 and May 25, 2021.

**TABLE 2: INVENTORY AND ISSUED**

| Item | Total Category 1 & 2 Inventory May 20, 2021 | Days on Hand May 20, 2021 | Products Issued March 1, 2020 to May 19, 2021 |
|---|---|---|---|
| Respirators | Government Financial Information | | |
| Masks (Surgical / Procedure) | | | |
| Gloves (pairs) | | | |
| Gowns | | | |
| Eye Protection | | | |
| **Total** | | | |

* Estimated days until product depletion, based on available inventory and monthly utilization rate. Does not include or consider future delivery of product. Presented as a range as there are a variety of models, sizes and/or levels for each product. For example, small vs. large size respirator, gloves and level 1 vs level 3 procedure masks, etc.

- From Government Financial Information
  Government Financial Information The remaining inventory provides a sufficient stockpile of these items should global and domestic supply chains become disrupted again.

### KEY FACTS

- In April 2021 the province implemented Stage 1 of the *COVID-19: Emergency Prioritization in Pandemic PPE Allocation Framework*, made possible by the increased stability of incoming PPE inventory and the current available inventory held in Category 1 and 2.

Government Financial Information

- The table below shows the various models of N95 respirators in inventory and the monthly utilization rates.

Government Financial Information

** Some models are on restriction due to limited incoming inventory from the supplier, other models remain allocation to health authorities to ensure adequate supply remains available where needed.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

May 27, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
June 1, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 7, 2021 – Peter Pokorny, Associate DM, Corporate Services

# LEGISLATIVE SESSION - FACT SHEET

## Personal Protective Equipment Quality Assessment

### TOPIC

All personal protective equipment (PPE) used in the BC health system goes through testing and assessment processes to evaluate and verify that PPE products in the supply chain meet relevant national and international standards to ensure the safety of health-care workers and patients.

### CURRENT SITUATION

- The global spread of COVID-19 has put an unprecedented strain on international supply chains, requiring a rapid evolution of the structures and quality assurance processes required to source appropriate PPE.
- The Ministry of Health is working closely with Provincial Health Services Authority (PHSA) and regional health authorities to provide appropriate PPE and ensure safe provision of health care in BC.
- The province has and is pursuing all credible leads, sourcing PPE from new suppliers, new models of PPE from existing suppliers, and obtaining donated PPE from the federal government and other sources. PPE from these sources is referred to as '*alternative PPE'.*
- While *alternative PPE* may be entirely suitable, it must be appropriately reviewed before being deemed appropriate for use in the health system. Products require valid documentation such as English Medical Device Establishment License from Health Canada authorizing the import or sale of PPE for medical purposes in Canada. This documentation is often incomplete when PPE arrives in the province and must be verified by PHSA employees. Some products also require additional testing.
- The Fraser Health Authority (FHA) and PHSA were tasked early in the pandemic to provide PPE Model Appropriateness Assessment, primarily of N95s. FHA, PHSA, Vancouver Coastal Health Authority (VCHA) and the Ministry developed a robust process flow document to ensure that all products using this process are assessed and inspected consistently. This work has been guided by the Provincial N95-PPE Supply Management Sub-Working Group.
- In March 2020, a PPE testing laboratory was established in VCHA and in October 2020, received accreditation from the Canadian Standards Association as a PPE testing laboratory; the lab is well positioned to develop capacity within BC and Canada to test PPE, including N95 respirators.

### KEY FACTS

- Assessment, Inspection, and testing are usually required to confirm quality. Laboratory testing is performed if documentation is incomplete, unavailable or there are concerns with validity of documentation or supplier.
- Using the BC PPE Supply, Assessment, Testing and Distribution Protocol, and the results of inspection, assessment and testing, BC classifies PPE into four discreet categories:[1]
    - **CATEGORY 1**: Existing inventory item from a known supplier and is in acceptable condition.
    - **CATEGORY 2**: Not a standard inventory item, meets all required standards and use requirements, is acceptable for use.
    - **CATEGORY 3**: Not a standard inventory item, does not meet all required standards, could be considered if no other options exist.
    - **CATEGORY 4**: Does not meet minimal acceptable standards and/or does not meet use requirements. Item is unacceptable and there is no potential or possibility of it ever being used in the health sector.
- Medical grade PPE that passes assessment and testing is put into category 1 and 2 inventory and those which do not pass fall into alternative, contingency or not for use in health care categories. Government Financial Government Financial Information

[1] BC PPE Supply, Assessment, Testing and Distribution Protocol, May 1, 2020 http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_PPESupplyAssessmentDistributionProtocol.pdf

[2] Cumulative Report for Deputy Minister, January 21, 2021.

- The PHSA Supply Chain has long-standing relationships with suppliers that provide PPE from trusted manufacturers. Item models that are already part of the Supply Chain inventory system Government Financial Information
Government Financial Information received from a known supplier can go directly to the PHSA distribution warehouses without further assessment or testing.
- Alternative PPE, regardless of the supplier, undergoes a PPE Appropriateness Assessment to determine whether it is an appropriate device to be used within the health care environment from a health and safety, and clinical perspective.
    - PPE from alternate sources, must be tested in accredited laboratories with results that meet or exceed National Institute for Occupational Safety and Health (NIOSH) standards that Health Canada requires for use in our health system, and American Society for Testing and Materials (ASTM). This includes all donations - some federal Bulk Procurement supplies and new vendor products.
    - The WorkSafeBC Occupational Health and Safety Regulation regarding approved respirators was revised in February 2021, to include the acceptance of Canadian Standards Association certification requirements for respirators as a standard acceptable to WorkSafeBC under section8.33(2) of the regulation.
- Testing alternative PPE has proven to be costly, with much of the samples being sent to laboratories out-of-country. Government Financial Information
Government Financial Information
- Costs associated with PPE testing completed at external laboratories between April 2020 and January 2021 are as follows:

| Agency | Cost (CDN) |
|---|---|
| Vancouver Coastal | Government Financial Information |
| Provincial Health Services Authority | |
| **TOTAL** | |

## FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**
March 12, 2021 - Ian Rongve, ADM, COVID Response and Health Management Division
April 28, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[3] PPE Testing Laboratory Expenses, July 15, 2020 Summary
[4] Melinda Mui, email communication, March 05, 2021.
[5] Fernando Pico, email communication November 30, 2020

Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

# Point of Care Testing for COVID-19

## TOPIC

Use of rapid point of care (POC) tests to support British Columbia's (BC) provincial response to the COVID-19 pandemic.

## CURRENT SITUATION

- Rapid POC testing has been underway in priority settings in BC since December 2020, including in long-term care, provincial corrections centres, urban underserved populations, rural and remote and Indigenous communities, to support outbreak investigations, and at the discretion of the Medical Health Officer.
- As of June 5, 2021, there have been 72,034 rapid point of care tests reported used in BC and 646 presumptive positive results. There have been 11,884 rapid point of care tests in long-term care and assisted living facilities and 3 presumptive positive results. See Appendix for detailed distribution and utilization of point of care tests in British Columbia.
- BC's Rapid POC Testing Strategy released March 4, 2021[1], permits wider use in workplaces and settings where there is a higher risk of outbreak and/or transmission including, but not limited to, industrial camps, food processing plants and post-secondary residences. The Strategy recommends POC testing for use in the following:
  - Community settings.
  - Places where rapid COVID-19 test results are needed to guide immediate public health action.
  - For screening in settings with increased risk of transmission.
- Organizations interested in providing rapid COVID-19 tests to asymptomatic individuals can establish POC screening programs if they are accredited under the Diagnostic Accreditation Program through the College of Physician and Surgeons or they may be eligible to access the BC Centre for Disease Control (BCCDC) Quality Assurance Program if the test is provided at no charge to the individual being tested.
- All organizations are required to report any positive results to public health for follow-up action. [2]
- Federally procured rapid POC testing kits can be accessed in 3 ways:
  - Through distribution to health authorities for use in healthcare and other priority settings with approval of the Medical Health Officer.
  - Industries and organizations may access rapid POC tests through the BCCDC Rapid COVID-19 POC Screening Program.
  - Industries and organizations operating in multiple jurisdictions may also access rapid POC tests from the Government of Canada Direct Delivery Program.
- Health Canada started authorizing use of rapid tests in Canada in fall 2020:
  - Abbott Panbio Nasal Pharyngeal (NP) was authorized October 5, 2020, and started shipping to BC November 10, 2020, and was validated for use in BC by the first week of December.
    - This test requires a healthcare professional to administer as it requires a NP swab.
  - Abbott ID Now PCR test was authorized September 30, 2020, and started shipping to BC October 26, 2020, and was validated for use in BC by the first week of December.
    - Abbott ID Now is a PCR test that requires an NP swab and because it can provide a COVID-19 diagnosis must be administered by a healthcare professional.
  - BD Veritor was authorized November 2, 2020, and started shipping to BC in November 2020. The BD Veritor requires an analyzer to interpret test results and analyzers were not made available until late January 2021. BC received one BD Veritor analyzer
    January 8, 2021, for validation use.
  - Abbott Panbio Nasal was authorized December 31, 2020, and started shipping to BC in early February 2021, and has been in use since late February.

[1] Rapid Point-of-Care Testing Strategy, March 4, 2021.

[2] BCCDC (2021) Rapid COVID-19 Point of Care Screening Program. Accessed March 23, 2021 from http://www.bccdc.ca/health-info/diseases-conditions/covid-19/testing/rapid-covid-19-point-of-care-screening-program.

        - It is the easiest to use of the rapid tests as it does not require a healthcare professional to administer or an analyzer device to interpret results.
    - On April 23, 2021 Health Canada issued authorization for a self-testing kit (**Lucira CHECKIT COVID-19 Test Kit)**, whereby an individual can swab and interpret test results on their own.
        - The Federal Government has procured 100,000 Lucira test kits and has asked provinces to identify pilots and potential uses. British Columbia has requested 1000 Lucira test kits from Health Canada. BC Centre for Disease Control (BCCDC) and Provincial Laboratory Medicine Services will begin validating these devices for use in clinical scenarios or run pilot programs as soon as they are received from Health Canada.
        - In a statement released April 26, 2021, the company said it planned to offer the test kits direct to consumer for $75.00 CAD exclusive of taxes and delivery by June 2021.
- As of April 22, 2021, self-administered lower nasal swabbing under the observation of a trained individual who is not required to be a healthcare professional is permitted and supported by a BCCDC quality assurance framework. For now, this only applies to use of Abbott Panbio nasal testing devices.

**Use in Long Term Care**

- As of May 28, 2021, rapid testing has been used at 11 facilities in the Fraser Health Authority and 20 facilities in the Vancouver Coastal Health Authority/Providence Health Care.
- 11,884 rapid tests have been used in LTC and AL facilities in British Columbia, resulting in 3 positive results being detected.
- To understand the utility and feasibility of POC testing in LTC, a pilot study was launched in December 2020, at LTC facilities across Vancouver Coastal Health and Providence Health Care.
- The pilot study found that rapid POC screening was more sensitive and objective compared to symptom screening checklists; required 1-2 dedicated staff to administer the screening programs; with high vaccination rates of LTC staff and residents it may need to shift focus from staff to visitors; and, the report notes it may play a role in the future due to incidents of immune escape with variants of concern or other strains.
- A report by the Congregate Care Setting Working Group and the Ontario COVID-19 Science Advisory Table, released March 23, 2021, found:
    - Asymptomatic screen testing of LTC staff in Ontario between June 2020, and March 2021, yielded 0.16% positivity. Given the high rates of protection of COVID-19 vaccines against symptomatic and asymptomatic infection, outside of an exposure or outbreak setting the potential harms and costs of screen testing among vaccinated LTC home staff outweigh the benefits, even when the B.1.1.7 variant is the dominant variant.
    - "A rapid review of the literature found no real-world evidence to either support or refute screen testing in preventing LTC home COVID-19 outbreaks. There are several direct harms associated with screen testing, as well as opportunity costs, including exacerbating LTC staffing shortages."
- LTC, AL and independent living facility operators in British Columbia can access rapid point of care testing kits through the following channels:
    - Regional health authorities under approval of the Medical Health Officer (MHO);
    - British Columbia's Rapid POC Screening Program administered by the Provincial Health Services Authority (PHSA); and
    - Government of Canada Direct Program for organizations operating in multiple provincial jurisdictions.
- On May 6, 2021, a presentation on the provincial program and how operators can access test kits was provided by the PHSA through the BC Care Providers Association and BC Safer Care sponsored Lunch and Learn series.

## KEY FACTS

- COVID-19 rapid POC testing is done outside the laboratory setting with results generated in a shorter time compared to gold standard laboratory-based Polymerase Chain Reaction (PCR) testing.

- All POC tests are approved by Heath Canada and supplied to provinces by the federal Government. The federal Government began shipping POC analyzers and test cartridges to provinces in October 2020.
- The *BCCDC* and *Provincial Laboratory Medicine Services* moved quickly to validate the use of POC devices in clinical scenarios. Tests were then distributed to health authorities, where implementation and confirmation of practical use in clinical testing workflows was determined.
- COVID-19 POC tests available in BC include rapid antigen tests and rapid nucleic acid amplification tests. Positive COVID-19 rapid POC results are followed up with a PCR test to confirm diagnosis of COVID-19.
- There are three POC tests available that have been approved by Health Canada and have undergone laboratory validation in BC:[3]
    - Abbott Panbio COVID-19 Antigen Rapid Test (Panbio) tests for COVID-19 antigens and does not require an analyzer. Results take about 15 minutes. The early shipments of Panbio required a nasal pharyngeal swab so those kits are now being retrofitted to use a nasal swab. The shelf life is 12 months.
    - Abbott ID NOW COVID-19 (ID NOW) looks for the virus genetic material in a nasal sample PCR. The test requires both a test kit and a portable analyzer. The analyzer can run 4 samples at once, and results take up to 1 hour. The shelf life is 6 months.
    - BD Veritor tests for antigens via a nasal swab and requires a portable analyzer. Results take about 20 minutes. The shelf life was initially 6 months but was recently extended to 12 months by the manufacturer.

## FINANCIAL IMPLICATIONS

Tests are supplied to BC by the federal Government free of cost. Any costs associated with delivering rapid POC tests are covered by the organization establishing the screening program.

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**Approved:**
June 11, 2021– Ian Rongve, ADM, COVID Response and Health Emergency Management Division

[3] Data collected from the Health Canada Eagle Report, accessed April 19, 2021.

## Appendix

Distribution of Point-of-Care Test Kits

- As of June 7, 2021, a total of 452,233 tests and 287 analyzers have been distributed in BC.[4] This includes:
  - 276 ID NOW analyzers across all health authority partners.
  - 52,632 ID NOW test cartridges across all health authority partners.
  - 11,904 ID NOW test cartridges for validation.
  - 269,575 Panbio nasopharyngeal test kits across all health authority partners.
  - 63,930 Panbio nasal swab kits across all health authority partners.
  - 11 BD Veritor readers (1 to Provincial Health Services Authority, 8 to Providence Health Care, and 2 to Fraser Health Authority).
  - 9,900 BD Veritor test kits to Provincial Health Services Authority (for validation) and Providence Health Care.
  - 32,692 test kits for industry testing through Iridia Medical, including:
    - 1,392 ID NOW cartridges.
    - 2,500 Panbio nasopharyngeal test kits.
    - 28,800 Panbio nasal swab kits.
  - 1,600 Panbio nasal swab kits for industry testing through Zanzibar (silviculture).
  - 400 Panbio nasal swab kits for industry testing through Paladin Security.
  - 9,600 Panbio nasal swab kits for testing through BC Wildfire Service.

Available Point-of-Care Test Kits

- As of June 7, 2021, the following remains in provincial warehouses[5] available in BC to be deployed to regions, a total of 2,369,538 tests and 337 analyzers,[6] this includes:
  - 112 ID NOW analyzers.
  - 588,168 ID NOW test cartridges.[7]
  - 910,150 Panbio nasopharyngeal test kits.[8]
  - 497,150 Panbio nasal swab test kits.
  - 225 BD Veritor readers.
  - 374,070 BD Veritor test kits.

[4] Data collected from PHSA Supply Chain Dashboard.
[5] The warehouses storing tests are Langley Fulfillment Centre, Hopcott, Bowers, and Agar.
[6] Data collected from PHSA Supply Chain Dashboard.
[7] Abbott ID Now tests were set to expire starting April 2021 with 7,872 tests expiring that month, then 23,160 tests expiring in May 2021, and 69,864 tests expiring in June 2021. The shelf-life has now been extended from 6 months to 9 months, so tests will start to expire in July 2021.
[8] Work is underway to retrofit the Panbio nasopharyngeal test kits so a lower nasal swab can be used instead.

# LEGISLATIVE SESSION - FACT SHEET

Point-of-Care Testing in British Columbia – Health Authorities and Provincial Program

As of **June 5, 2021**, the following tests have been used (ID NOW, Panbio and BD Veritor):

| Source | Lead | Name of Site | Type of Site | Number of Tests Used | Presumptive Positive Results |
|---|---|---|---|---|---|
| Health Authority Use | FHA | Royal Columbian Hospital | Hospital pre-surgery | 1817 | 7 |
| | | Menno Independent Living | LTC/AL/IL | 49 | 0 |
| | | School Outbreaks | Outbreak | 482 | 9 |
| | | Worksite Outbreaks | Outbreak | 3070 | 55 |
| | | Surrey Emergency Response Center | Urban underserved population | 450 | 4 |
| | | Surrey Olive Branch Shelter | Urban underserved population | 7 | 0 |
| | | Salvation Army | Urban underserved population | 37 | 0 |
| | | Chilliwack Portal Shelter | Urban underserved population | 86 | 0 |
| | | The COVE (Surrey) | Urban underserved population | 20 | 0 |
| | | SUMS Place (Surrey) | Urban underserved population | 18 | 0 |
| | | Suncreek Village | LTC/AL/IL | 240 | 0 |
| | | Sunset Manor | LTC/AL/IL | 233 | 0 |
| | | Willingdon Care Centre | LTC/AL/IL | 304 | 0 |
| | | Royal City Manor | LTC/AL/IL | 502 | 0 |
| | | Hawthorne Seniors Care | LTC/AL/IL | 490 | 0 |
| | | Menno Home and Hospital | LTC/AL/IL | 579 | 1 |
| | | Langley Lodge | LTC/AL/IL | 388 | 0 |
| | | Fleetwood Villa Surrey | LTC/AL/IL | 189 | 0 |
| | | Whitecliff South Surrey | LTC/AL/IL | 56 | 0 |
| | | Holyrood Manor, Revera Living Maple Ridge | LTC/AL/IL | 136 | 0 |
| | | Hyland House | Urban underserved population | 52 | 0 |
| | | Gateway of Hope | Urban underserved population | 12 | 0 |
| | | Warm Zone | Urban underserved population | 4 | 0 |
| | | Penny's Place | Urban underserved population | 6 | 0 |
| | | Mission Emergency Shelter | Urban underserved population | 16 | 7 |
| | | Abbotsford Regional Hospital | Hospital pre-surgery | 20 | 0 |
| | | Surrey Urban Mission Society | Urban underserved population | 69 | 0 |
| | | Fellburn Care Centre | LTC/AL/IL | 2 | 0 |
| | | Burnaby Isolation Centre | Urban underserved population | 3 | 1 |
| | | | **FHA Total:** | **9,337** | **84** |
| | FNHA | Okanagan Indian Band | Outbreak | 1 | 1 |
| | | Westbank | Rural/remote | 405 | 19 |
| | | Tahltan | Rural/remote | 4 | 0 |
| | | Takla Nation Clinic | Rural/remote | 3 | 0 |

# LEGISLATIVE SESSION - FACT SHEET

| Source | Lead | Name of Site | Type of Site | Number of Tests Used | Presumptive Positive Results |
|---|---|---|---|---|---|
| Health Authority Use | FNHA | Pine Acres Home | Rural/remote | 8 | 0 |
| | | Saulteau First Nation | Rural/remote | 5 | 0 |
| | | Southside Health & Wellness Centre - Carrier Sekani Family Services | Rural/remote | 4 | 0 |
| | | Three Corners Health Services Society | Rural/remote | 5 | 0 |
| | | | **FNHA Total:** | **435** | **20** |
| | IHA | Williams Lake | Outbreak | 38 | 0 |
| | | Sparwood | Outbreak | 8 | 0 |
| | | Kamloops | Urban underserved | 44 | 1 |
| | | Vernon | Urban underserved | 21 | 5 |
| | | Kelowna | Validation ID NOW | 2 | 0 |
| | | Kelowna General Hospital | Validation Panbio | 80 | 0 |
| | | Penticton | Other - Training | 55 | 1 |
| | | Royal Inland Hospital | Validation Panbio | 361 | 0 |
| | | Interior Health Wide | Hospital pre-surgery | 1680 | 1 |
| | | Penticton LTC | LTC/AL/IL | 12 | 0 |
| | | | **IHA Total:** | **2,301** | **8** |
| | NHA | UHNBC, Prince George | Validation ID NOW | 152 | 0 |
| | | Brucejack Mine | Worksite Training | 166 | 1 |
| | | Stikine Health | Rural/remote | 58 | 0 |
| | | Red Chris Mine | Worksite Training | 100 | 3 |
| | | Knights Inn - Prince George MHSU | Urban underserved population | 33 | 1 |
| | | Mills Memorial Hospital | Hospital presurgery | 644 | 1 |
| | | | **NHA Total:** | **1,153** | **6** |
| | PHSA | BCCW | Validation ID NOW | 216 | 0 |
| | | BC Centre for Disease Control | Validation ID NOW | 432 | 0 |
| | | BD Veritor Validation | Validation BD Veritor | 720 | 0 |
| | | Forensic Psychiatric Hospital | Mental Health and Substance Use | 127 | 0 |
| | | Burnaby Centre for Mental Health & Addictions | Mental Health and Substance Use | 132 | 0 |
| | | Surrey Pretrial Correctional Centre | Corrections | 1366 | 43 |
| | | North Fraser Pretrial Correctional Centre | Corrections | 1126 | 18 |
| | | Alouette Correctional Centre for women | Corrections | 213 | 4 |
| | | Okanagan Correctional Centre | Corrections | 334 | 4 |
| | | Prince George Correctional Centre | Corrections | 516 | 8 |
| | | Vancouver Island Correctional Centre | Corrections | 528 | 3 |
| | | Kamloops Correctional Centre | Corrections | 172 | 1 |
| | | Fraser Regional Correctional Centre | Corrections | 41 | 1 |
| | | Nanaimo Correctional Centre | Corrections | 0 | 0 |
| | | Ford Mountain Correctional Centre | Corrections | 44 | 0 |
| | | | **PHSA Total:** | **5,967** | **82** |

# LEGISLATIVE SESSION - FACT SHEET

| Source | Lead | Name of Site | Type of Site | Number of Tests Used | Presumptive Positive Results |
|---|---|---|---|---|---|
| Health Authority Use | VCHA/PHC | Acute - discontinued | Acute | 22 | 0 |
| | | LTC - discontinued | LTC/AL/IL | 10 | 0 |
| | | LTC discontinued | LTC/AL/IL | 19 | 0 |
| | | Validation | Validation Panbio | 0 | 0 |
| | | Villa Carital | LTC/AL/IL | 2041 | 0 |
| | | Holy Family Hospital - Residential | LTC/AL/IL | 297 | 0 |
| | | Sunrise of Vancouver | LTC/AL/IL | 2486 | 1 |
| | | Mt St Josephs | LTC/AL/IL | 0 | 0 |
| | | Minoru Residence | LTC/AL/IL | 859 | 1 |
| | | DTES | Urban underserved population | 431 | 70 |
| | | Holy Family Rehabilitation | Other - Rehab | 37 | 0 |
| | | St. Paul's Hospital ED | Urban underserved population | 81 | 3 |
| | | St. Paul's Hospital - Cardiac Unit | Outbreak | 908 | 3 |
| | | Whistler Respiratory Assessment Centre | Outbreak | 1027 | 255 |
| | | Three Links Manor | LTC/AL/IL | 1090 | 0 |
| | | Richmond Lions Manor | LTC/AL/IL | 575 | 0 |
| | | UBC Orchard Residence | Post Secondary Residence | 4087 | 33 |
| | | Little Mountain Place | LTC/AL/IL | 308 | 0 |
| | | German Canadian Care Centre | LTC/AL/IL | 422 | 0 |
| | | Lakeview Care Centre | LTC/AL/IL | 568 | 0 |
| | | Legacy Senior Living | LTC/AL/IL | 183 | 0 |
| | | Rosewood Manor | LTC/AL/IL | 224 | 0 |
| | | Edgemont Village-Amica | LTC/AL/IL | 12 | 0 |
| | | Hollyburn House - Revera | LTC/AL/IL | 609 | 0 |
| | | Crofton Manor - Revera | LTC/AL/IL | 304 | 0 |
| | | Lions Gate-Amica | LTC/AL/IL | 41 | 0 |
| | | West Vancouver-Amica | LTC/AL/IL | 19 | 0 |
| | | Windermere | LTC/AL/IL | 235 | 0 |
| | | Hofn Icelandic Harbour | LTC/AL/IL | 52 | 0 |
| | | Royal Ascot Care Centre | LTC/AL/IL | 6 | 0 |
| | | Capilano Care Centre | LTC/AL/IL | 80 | 0 |
| | | Arbutus Care Centre - Revera | LTC/AL/IL | 53 | 0 |
| | | Pinegrove | LTC/AL/IL | 33 | 0 |
| | | | **VCH/PHC Total:** | **17,119** | **366** |
| | VIHA | VGH hospital lab | Validation Panbio | 79 | 0 |
| | | VGH POCT | Validation ID NOW | 92 | 0 |
| | | Zeballos Health Centre | Rural/remote | 73 | 7 |
| | | Nanaimo Community-MHSU | Urban underserved population | 144 | 1 |
| | | Cortes Health Centre | Rural/remote | 88 | 0 |
| | | CAMICO | Urban underserved population | 134 | 1 |
| | | Bamfield Health Centre | Rural/remote | 70 | 0 |
| | | Courtenay/Comox Collection Site | Collection Site | 111 | 5 |
| | | Cowichan Collection Site | Collection Site | 60 | 10 |
| | | Nanaimo Collection Site | Collection Site | 44 | 0 |

# LEGISLATIVE SESSION - FACT SHEET

| Source | Lead | Name of Site | Type of Site | Number of Tests Used | Presumptive Positive Results |
|---|---|---|---|---|---|
| Health Authority Use | VIHA | Lady Minto ED (Salt Spring Island) | Rural/remote | 161 | 0 |
| | | Campbell River Collection Site | Collection Site | 75 | 1 |
| | | Victoria UVIC #1 | Collection Site | 10 | 0 |
| | | Saanichton/Sidney (Peninsula Health Unit) | Other - Training | 5 | 0 |
| | | Victoria ICBC | Other - Training | 6 | 0 |
| | | Nanaimo Regional General Hospital - PES | Other - Training | 17 | 0 |
| | | Royal Jubilee Hospital - PES | Other - Training | 27 | 0 |
| | | CVH Psych | Other - Training | 18 | 0 |
| | | Oceanside Health Centre | Other - Training | 29 | 1 |
| | | Gold River Health Centre | Rural/remote | 7 | 0 |
| | | Tofino General Hospital | Rural/remote | 14 | 0 |
| | | | **VIHA Total:** | **1,264** | **26** |
| | | | **Health Authority Total:** | **37,576** | **592** |
| Rapid COVID-19 Screening Program | Iridia Medical | Red Chris Mine | Workplace Use | 3606 | 0 |
| | | Red Chris YVR | Workplace Use | 500 | 0 |
| | | Red Chris Clinic | Workplace Use | 133 | 0 |
| | | Brucejack | Workplace Use | 4646 | 1 |
| | | Wildfire | Workplace Use | 1562 | 0 |
| | | Coast Guard Prince Rupert | Workplace Use | 304 | 0 |
| | | Coast Guard Victoria | Workplace Use | 6 | 0 |
| | | Iridia Training | Workplace Use | 56 | 0 |
| | | Barkerville Gold Mine | Workplace Use | 563 | 2 |
| | | Knipple Camp | Workplace Use | 673 | 0 |
| | | Pretivm YVR | Workplace Use | 479 | 0 |
| | | Parkland Refinery | Workplace Use | 59 | 0 |
| | | Brinkman (CC) Reforestation (Silviculture) | Workplace Use | 15 | 0 |
| | | Brinkman (PG) Reforestation (Silviculture) | Workplace Use | 32 | 0 |
| | | Brinkman (Kamloops) Reforestation (Silviculture) | Workplace Use | 30 | 0 |
| | | Kemano Mines - Rio Tinto | Workplace Use | 605 | 0 |
| | | Quastuco Reforestation (Silviculture) | Workplace Use | 137 | 0 |
| | | Dease Lake - Telegraph Creek Community | Workplace Use | 106 | 0 |
| | | Novus Film | Workplace Use | 56 | 0 |
| | | A&G Reforestation Cache Creek | Workplace Use | 127 | 0 |
| | | A&G Reforestation Princeton | Workplace Use | 127 | 0 |
| | | Brinkman Little Fort | Workplace Use | 19 | 0 |
| | | Pretivm Terrace/Whitecap | Workplace Use | 626 | 0 |
| | | Red Chris Main | Workplace Use | 2551 | 2 |
| | | Seabridge | Workplace Use | 132 | 0 |
| | | Galore Creek Mines | Workplace Use | 151 | 0 |
| | | Kingfisher Mines | Workplace Use | 14 | 0 |
| | | Pretivm Smithers Total Physio | Workplace Use | 25 | 0 |
| | | Seabridge - Bell 2 | Workplace Use | 50 | 0 |
| | | Seabridge - KSM | Workplace Use | 8 | 0 |
| | | Seabridge 3 Aces | Workplace Use | 0 | 0 |

# LEGISLATIVE SESSION - FACT SHEET

| Source | Lead | Name of Site | Type of Site | Number of Tests Used | Presumptive Positive Results |
|---|---|---|---|---|---|
| Rapid COVID-19 Screening Program | Iridia Medical | Talisker - Bralorne | Workplace Use | 2 | 0 |
| | | Talisker - Lillooet | Workplace Use | 23 | 0 |
| | | | **Iridia Total:** | **17,423** | **5** |
| | | | **Workplace Screening Total:** | **17,423** | **5** |
| | **Total Provincial Supply Tests Used in British Columbia** | | | **54,999** | **597** |
| | **to June 5, 2021** | | | | |

Point-of-Care Testing in British Columbia Using Government of Canada Direct Delivery

As of June 5, 2021, the following tests have been used (ID NOW, Panbio and BD Veritor):

| Government of Canada Direct Delivery Test Usage in BC | | | | |
|---|---|---|---|---|
| **Lead Partner** | **Name of Site** | **Type of Site** | Number of Tests Used | **Presumptive Positive Results** |
| | Aritzia | Workplace Use – Fed Direct | 2,829 | 1 |
| | Brinkman | Workplace Use – Fed Direct | 365 | 0 |
| | Famous Wok | Workplace Use – Fed Direct | 54 | 0 |
| | KF Aerospace | Workplace Use – Fed Direct | 316 | 0 |
| | London Drugs | Workplace Use – Fed Direct | 401 | 6 |
| | Recipe Unlimited | Workplace Use – Fed Direct | 388 | 0 |
| | Rio Tinto Diavik Diamond Mine | Workplace Use – Fed Direct | 135 | 0 |
| | TC Energy | Workplace Use – Fed Direct | 1,290 | 0 |
| | Teck Resources North Vancouver | Workplace Use – Fed Direct | 6,051 | 24 |
| | Teck Resources Sparwood | Workplace Use – Fed Direct | 1,488 | 11 |
| | Teck Resources Kimberley | Workplace Use – Fed Direct | 206 | 0 |
| | Teck Resources Trail | Workplace Use – Fed Direct | 224 | 0 |
| | Teck Resources Elkford | Workplace Use – Fed Direct | 3,257 | 7 |
| | Teck Resources Spences Bridge | Workplace Use – Fed Direct | 31 | 0 |
| **Total Federal Direct Delivery Tests Used in British Columbia** | | | **17,035** | **49** |
| **As of June 5, 2021** | | | | |

# LEGISLATIVE SESSION - FACT SHEET

Point-of-Care Test Distribution from Provincial Supply

As of **June 7, 2021**, the following tests have been distributed (ID NOW, Panbio and BD Veritor):

| Health Authority | Panbio | ID Now | BD Veritor | Total | Analyzer ID Now | Analyzer BD Veritor | Total |
|---|---|---|---|---|---|---|---|
| Northern Health | 1,375 | 3,120 | - | **4,495** | 25 | - | **25** |
| Island Health | 52,325 | 5,424 | - | **57,749** | 25 | - | **25** |
| Vancouver Coastal Health | 70,725 | 10,536 | 8,820 | **90,081** | 70 | 8 | **78** |
| Fraser Health | 19,655 | 9,864 | - | **29,519** | 47 | 2 | **49** |
| Interior Health | 9,550 | 11,544 | - | **21,094** | 79 | - | **79** |
| Provincial Health | 4,625 | 8,424 | 1,080 | **14,129** | 20 | 1 | **21** |
| First Nations Health | 175,200 | 3,720 | - | **178,920** | 10 | - | **10** |
| Industry (Iridia) | 31,300 | 1,392 | - | **32,692** | - | - | **-** |
| Industry (Amica) | 50 | | | **50** | | | **-** |
| Industry (Zanzibar) | 1,600 | | | **1,600** | | | |
| Industry (Paladin Security) | 400 | | | **400** | | | |
| BC Wildfire Service | 9,600 | | | **9,600** | | | |
| Other (Validation) | | 11,904 | | **11,904** | | | **-** |
| **Total** | **376,405** | **65,928** | **9,900** | **452,233** | **276** | **11** | **287** |

Government of Canada Direct Delivery Program Distribution in British Columbia[9]

| Company Name | Location | Provinces Where Screening Will Occur[10] | Type of Test | Number of Tests |
|---|---|---|---|---|
| **Shipped/In Fulfillment** | | | | |
| Air Canada – Order #3 | n/a | BC, AB, QC | n/a | 16,020 |
| Aritzia LP | Vancouver | BC, AB, ON, QC | Panbio | 8,200 |
| Aritzia LP – Order #2 | n/a | BC, AB, ON | n/a | 15,000 |
| Brinkman Reforestation Ltd. | n/a | BC, AB, ON | n/a | 12,000 |
| Canada Post | n/a | All | n/a | 5,000 |
| Canadian Red Cross | n/a | BC, AB, MB, NB, NL, NS, ON, PE, QC, SK | n/a | 9,600 |
| Cargojet Airways Ltd. | n/a | All | n/a | 10,000 |
| CFL Enterprises LP | n/a | BC, AB, MB, ON, QC, SK | n/a | 30,000 |
| Choice Properties REIT | n/a | BC, QC, NS, ON, NB, AB | n/a | 10,000 |
| Donald's Fine Foods - BC Operations | Richmond | BC | BD Veritor | 4,500 |
| EHN Canada | n/a | BC, AB, NS, ON, QC | n/a | 4,000 |
| Famous Wok | n/a | BC, AB, ON, MB | n/a | 1,500 |
| GardaWorld | Montréal | BC, QC, ON, MB, AB | Panbio | 12,000 |
| JD Irving | n/a | BC, AB, NB, PE | n/a | 10,000 |

[9] This list includes organizations participating in the Government of Canada Direct Delivery Program.
[10] Number of tests for use in BC is unknown; shipping is to multiple provinces.

# LEGISLATIVE SESSION - FACT SHEET

| Company Name | Location | Provinces Where Screening Will Occur[10] | Type of Test | Number of Tests |
|---|---|---|---|---|
| JD Irving – Order #2 | n/a | BC, AB, NL, NV | n/a | 2,000 |
| Lafarge | n/a | BC, AB, MB, SK | n/a | 4,000 |
| London Drugs | Richmond | BC | BD Veritor | 3,300 |
| Martin-Brower of Canada | n/a | BC, AB, MB, NB, ON, QC | n/a | 2,000 |
| MasterBUILT Hotels Ltd. | n/a | BC, AB, SK, MB, QC | n/a | 2,400 |
| Motion LP | n/a | BC, AB, SK, ON | n/a | 3,200 |
| Nandos Peri | n/a | BC, AB, ON | n/a | 1,000 |
| National Logistics Services (2006) Inc. | n/a | BC, ON | n/a | 1,800 |
| National Logistics Services (2006) Inc. – Order #2 | n/a | BC, ON | n/a | 800 |
| Reiser Canada Co. Ltd. | n/a | BC, AB, NB, QC, ON | n/a | 2,000 |
| Rexall Pharmacy Group – Order 3 | n/a | BC, ON, MB, NB, SK | n/a | 3,000 |
| Rio Tinto | n/a | BC, AB, MB, ON, NS, NL, NWT, YK | n/a | 9,660 |
| Rosenau Transport Ltd. | n/a | BC, AB, MB, NT, SK, YK | n/a | 1,000 |
| Savaria Lifts Concord Inc. | n/a | BC, ON, QC | n/a | 2,000 |
| Save-on-Foods | n/a | BC, AB, SK, MB | n/a | 1,410 |
| SNC Lavalin | Richmond | BC | Panbio | 1,000 |
| SNC Lavalin – Order 2 | n/a | BC, NS, ON, QC | n/a | 8,800 |
| St. Louis Franchise Limited | n/a | BC, AB, MB, NB, NL, NS, ON, PE, QC | n/a | 8,628 |
| TC Energy | Acheson | BC | Panbio | 5,000 |
| TC Energy – Order #2 | n/a | BC, ON, AB | n/a | 1,000 |
| Teck Resources | Vancouver | BC | Panbio | 71,200 |
| The Cadillac Fairview Corporation Limited | n/a | BC, AB, MB, NB, QC, ON (ON as pilot) | n/a | 18,000 |
| Total Credit Recovery Limited | n/a | BC, AB, ON, QC | n/a | 3,200 |
| Trans Mountain | Calgary | BC, AB | BD Veritor | 3,300 |
| VIA Rail Canada Inc. | n/a | BC, MB, NB, ON, QC | n/a | 6,600 |
| WestJet Partnership | n/a | BC, AB, MB, ON, QC, SK | n/a | 25,000 |
| **Due Diligence Complete** | | | | |
| Andritz Hydro Canada Inc. | n/a | BC, NL, ON, QC, SK, YK | n/a | 1,000 |
| B2Gold Corp | n/a | BC | n/a | 2,500 |
| Below the Belt | n/a | BC, AB, MB, ON, SK | n/a | 1,000 |
| Cloverdale Paint Inc | n/a | BC, AB, MB, ON, QC, SK | n/a | 1,000 |
| Costco Wholesale Canada | n/a | BC, ON | n/a | 5,000 |
| Eagle Ride Consulting Inc. | n/a | BC | n/a | 1,000 |

# LEGISLATIVE SESSION - FACT SHEET

| Company Name | Location | Provinces Where Screening Will Occur[10] | Type of Test | Number of Tests |
|---|---|---|---|---|
| EllisDon Construction Services | n/a | BC, AB | n/a | 12,200 |
| Flair Airlines | n/a | BC, AB, ON | n/a | 2,400 |
| Kevito Group | n/a | BC, ON | n/a | 3,500 |
| National Energy Equipment | n/a | BC, AB, MB, NB, NL, NS, ON, QC, SK | n/a | 1,040 |
| Princess Auto | n/a | BC, AB, MB, NB, NL, NS, ON, PE, QC, SK | n/a | 13,168 |
| Volkswagon Group Canada | n/a | BC, AB, ON | n/a | 1,000 |

# LEGISLATIVE SESSION - FACT SHEET

## Post COVID-19 Interdisciplinary Clinical Care Network (Recovery Clinics)

### TOPIC

In partnership with the regional health authorities, patients, and research organizations across BC, Provincial Health Services Authorities Post COVID-19 Interdisciplinary Clinical Care Network (PC-ICCN) aims to support the best possible outcomes for people who have experienced serious cases of COVID-19, through best practices, education, and research. Three Post COVID-19 Recovery Clinics have been established to date under the PC-ICCN umbrella.

### CURRENT SITUATION

- Much is still unknown about the long-term impacts of COVID-19, with research suggesting some people experience symptoms long after they have passed the infectious stage. It is estimated by international studies that 75% of hospitalized patients and 10% of non-hospitalized patients will require follow-up care.
- BC has established care for people with post COVID-19 symptoms, including interdisciplinary clinics, supports for primary care providers, and resources to help those affected manage their symptoms.
- The PC-ICCN is the first network of its kind in Canada to standardize post COVID-19 care across health authorities and integrate real-time research into clinical care. Researchers involved in the PC-ICCN are affiliated with a wide range of institutions, including the BC Academic Health Sciences Network; Simon Fraser University Faculty of Health Science; University of British Columbia, Faculties of Medicine and Nursing and the School of Population and Public Health; Canadian Institutes of Health Research ; Michael Smith Foundation for Health Research; BC SUPPORT Unit; and the Canadian COVID-19 Prospective Cohort Study.
- The PC-ICCN provincial approach ensures people in BC receive truly evidence-informed care from a group of committed physicians and interdisciplinary specialist teams with a common aim to improve outcomes for both patients and the system.
- The PC-ICCN aims to support the best possible outcomes for people recovering from lingering symptoms after COVID-19 infection, through research, education, and care.
- A core element of post COVID-19 research is PC-ICCN's patient registry and biobank. When a patient visits a Post COVID-19 Recovery Clinic (PCRC), a standardized set of tests are performed. If a patient agrees, biological samples from these tests can be used for research and stored in a biobank to support research.
- Patients will also be able to fill out questionnaires and be linked to several other research opportunities.
- COVID-19 survivors with complex presentations who do not receive adequate and evidence-based recovery care are at risk of lifetime disability and chronic diseases such as cardiovascular, respiratory, kidney disease and the known burden of depression and psychological impacts of chronic disease. These, in the aggregate, will lead to a high burden of care for patients, families and the health-care system.
- The PCRCs offer an opportunity to reduce hospital re-admissions for lingering COVID-19 symptoms and an opportunity to coordinate specialist referrals and reduce redundant lab and diagnostic testing. Working together as a network, the PC-ICCN can learn from and plan for the short, medium, and long-term resource needs for the population recovering from COVID-19.

### KEY FACTS

- In April 2020, the PC-ICCN was conceived of and formalized in the fall of 2020. It was not designed as a long-term solution and is expected to continue to the end of March 2022, with a determination to be made at that time whether a further extension is required or if usual care teams and research processes can support the work.
- There are 3 PCRCs in BC under the PC-ICCN umbrella: St. Paul's Hospital, Vancouver General Hospital, and the Jim Pattison Outpatient Care and Surgical Centre in Surrey.
    - A clinic at the Abbotsford Regional General Hospital is being officially launched in July 2021 (following a soft launch in May 2021), and there are development plans for Interior Health Authority and Vancouver Island Health Authority clinics. It is estimated the Interior Health clinic will launch in September, while the launch date for the Vancouver Island Health clinic is not yet known.

    - The PC-ICCN is working with the Provincial Health Services Authority Office of Virtual Health and regional health authority virtual health teams to leverage virtual care when patients recovering from COVID-19 cannot attend one of the established PCRCs.
- As of May 4, 2021, 656 patients have visited post COVID-19 recovery clinics in BC and 1,400 people have registered. Of the visits to date:
    - 135 were to the Jim Pattison Outpatient Care and Surgery Centre in Surrey.
    - 235 were to Vancouver General Hospital.
    - 277 were to St. Paul's Hospital in Vancouver.
    - 9 were to the Abbotsford Regional General Hospital (as part of a soft launch ahead of the official launch of the clinic).
- Patients access PCRCs for a finite period of time, between 6 and 18 months depending on clinical status.
    - The PCRC model of care is to see hospitalized patients at 3, 6, 12 and 18-months post-symptom onset.
    - All other patients are seen at 3-6 months for follow-up.
    - Discharge occurs at 6, 12, or 18 months depending on the severity of the illness.
- PCRCs offer unique care and leverage existing resources and care pathways while helping patients and their General Practitioners navigate this new disease. These clinics save the health-care system the costs of multiple specialist referrals, redundant lab and diagnostic testing, and costs for patients to travel to obtain these services.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
May 27, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Stock of Essential Supplies

### TOPIC

Inventory personal protective equipment and critical supplies for health care workers throughout the COVID-19 pandemic and vaccine roll out.

### CURRENT SITUATION

- The Ministry of Health, working with the Provincial Health Services Authority (PHSA) Supply Chain, continues to build a stockpile of essential supplies (personal protective equipment (PPE), immunization, vaccine supplies, testing and lab equipment) throughout the COVID-19 pandemic.
- Stockpile inventory expectations for PPE and critical supplies have been developed and updated over the last year to ensure the health care system is prepared to manage COVID-19 cases when surges and outbreaks occur.
- There is currently a 6 to 9-month inventory for most items.
- Stockpile expectations consider the full range of health system needs, from the PPE required to protect health care workers, patients and their families, to cleaning supplies and sanitizers required to keep facilities and workers safe, and equipment required to deliver on major health care initiatives including the COVID-19 vaccine roll-out.
- To further bolster our provincial long-term supply and stockpile, the Ministry has partnered with the federal government to secure international supply and increase domestic production of PPE and critical supplies.
- The Ministry is also working with third-party global supply chain experts to source international procurement opportunities.

### KEY FACTS

- The Province has been very successful in managing the available PPE during the initial wave of the pandemic in March 2020, up to present day.
- A significant effort has been made to keep pace with demand to ensure that health care workers have the PPE they need, and the Province continues to build new emergency supply.
- Canada's foreign PPE sources are the United States and China; both countries have experienced major supply chain disruptions due to ongoing global PPE demand.

Intergovernmental Communications; Government Financial Information

- Initiatives at the federal and provincial level in Canada are underway to support domestic manufacturing PPE. For example, first shipments of N95 respirators from the 3M manufacturing plant in Brockton, Ontario have started to arrive in smaller amounts and are expected to continue arriving in British Columbia over the next eight months.Government Financial Information

Government Financial Information

- PHSA, the Ministry and KPMG continue to partner with the vendor community to identify sourcing opportunities to increase available supply beyond what has historically been purchased and ensure a continuous monthly delivery of critical PPE items.
- The following table identifies the July 2020 stockpile inventory expectation set for PPE. These estimates were based on increased surgery capacity (at 130%), provincial masking policy (pre-November 2020) and anticipated COVID-19 rates.

| PPE Category | Volume Target[4] *July 2020* |
|---|---|
| **Procedure and Surgical Masks** | 58.1 million |
| **N95 Respirators or Equivalents** | 6.0 million |
| **Gloves (pairs)** | 349.71 million |
| **Gowns** | 2.4 million |

- Of note, supplies of N95s, gloves and gowns vary due to availability of sizes and types.
- BC has kept supplies flowing to the health care system over the past year and has exceeded stockpile expectations for most items.

Government Financial Information

## FINANCIAL IMPLICATIONS

The acquisition of PPE supplies is being managed through the PHSA in consultation with the Ministry. The PPE-related costs, including possible inventory valuation adjustments that may be required as a result of the year-end inventory audit, will not be available until after the close of the 2020/21 fiscal year-end and the external audit of PHSA's financial statements has been completed. This information will be publicly disclosed with the release of the Government's 2020/21 Public Accounts.

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**Approved:**

June 1, 2021 - Ian Rongve, ADM, COVID Response and Health Management Division

June 2, 2021 – Gordon Cross, obo Philip Twyford, ADM Finance and Corporate Services Division

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[1] USA, Federal Emergency Management Agency, source: https://www.fema.gov/disasters/defense-production-act

[2] USA, Federal Emergency Management Agency, source: https://www.fema.gov/fact-sheet/allocation-rule-personal-protective-equipment-exports

[3] PHAC 3M Canada: Projected Year 1 Provincial and Territorial Allocation Options, March 3, 2021

[4] Henry/Dix - COVID-19 update, announced July 20, 2020.

[5] March 1, 2021 PPE Summary

[6] Ibid

# LEGISLATIVE SESSION - FACT SHEET

# Supply Chain Management for COVID-19

## TOPIC

Overview of supply chain management activities and strategies for the health sector during the COVID-19 pandemic and vaccine planning.

## CURRENT SITUATION

- The Ministry of Health and the Provincial Health Services Authority (PHSA) continue to collaborate daily with provincial public and private sector partners on efforts to ensure personal protective equipment (PPE) and critical supplies are available to keep the health system operating and safe during the COVID-19 pandemic and vaccine roll out.
- Items that have been centrally housed, tracked, and distributed include: N95 respirators, medical masks, gloves, gowns, eye protection, immunization/vaccine equipment, disinfectants, laboratory and point of care COVID testing supplies, and other relevant consumable products.
- Current provincial supply chain is managed within a collaborative framework of guidelines, planning and policy including: centralized supply chain warehousing, tracking and distribution model; detailed mapping of supply availability to Public Health Orders and Ministry/BC Centre for Disease Control guidelines and policy; guidelines for conserving PPE and increased medical device reprocessing; transparent PPE and critical supply allocation models with the regional health authorities and community practitioners (general practitioners, community physicians, nurse practitioners, midwives); and, acquisition of warehouse space to accommodate substantially increased volumes of equipment, including for vaccine planning.
- As part of the support to the Province's *Restart Plan*, the Ministry and PHSA continue to support Emergency Management BC and the Ministry of Citizens' Services to assist PPE needs in the non-health sector and the *Restart Plan*.

## KEY FACTS

- PPE health care supply is primarily managed by the PHSA Supply Chain; health authorities order PPE supplies from the PHSA and may also procure critical supplies from other sources. See the fact sheet on the **Health PPE Portal** for information on general practitioners and community specialists' access to PPE and cleaning supplies from PHSA.
- Starting in Spring 2020, the PHSA and Ministry implemented a daily inventory system with a product dashboard to increase transparency, improve the distribution of supply and amalgamation of inventory across all health authority locations. This process has assisted the regional health authority teams to provide PPE to the right site at the right time, especially during times of increased COVID-19 rates.
- Resources have been made available by the Ministry for the PHSA to source additional PPE, strengthen relationships with regular vendors as well as to build out on-hand inventory/capacity.
- In addition to increased efforts to procure inventory, various PPE conservation strategies (e.g. guidelines to collocate COVID patients in a hospital ward and re-processing respirators) were immediately implemented in Spring March 2020 and continue today.
- Working with Health Canada and British Columbia Centre for Disease Control guidance, as of April 12, 2021, approximately 154,000 N95 respirators have been reprocessed in British Columbia (more continue to be reprocessed weekly).[1] These respirators are available for use in the event that inventory becomes significantly depleted and supplies are interrupted again. In addition, over 48,000 reusable elastomeric masks have also been reprocessed.[2] Utilization of elastomeric respirators that can be reused multiple times is estimated to have saved approximately 193,500 N95s in the healthcare system.[3]
- Since April 2020, a risk assessment process for PPE items has been used to assign an appropriate supply for health authorities based on PPE drivers for demand such as: pandemic outbreak locations, inpatient beds, surgical cases completed and population-based needs. Decisions are undertaken by a team consisting of representatives from the PHSA, the Ministry, and health authorities. Between April 2020 and April 19, 2021, the following items required allocation:

- N95 1860, 1860S and 1870+ **(respirators)**
- Hospital grade disinfectant wipes and 1 litre hand sanitizer refill
- Cavi disinfectant wipes
- S, M, L, XL nitrile gloves intermittently

- N95s continue to be the most competitive supply chain item globally. Government Financial Information Government Financial Information

- In Spring 2021, we expect to begin receiving monthly shipments Government Financial Information Government Financial Information

Government Financial Information The Ontario 3M plant has received funding from both the federal government and the Province of Ontario.

- The first shipment Governm of 1870+ respirators from the Ontario 3M plant arrived April 16, 2021.
- British Columbia is currently procuring, testing, and performing quality assurance on other types of respirators that can be substituted for the 1870+, 1860 and 1860s models. The province continues to test and perform quality assurance on all PPE prior to accepting into inventory.

***PPE that has arrived in British Columbia between March 1, 2020 and April 12, 2021[7]***

| PPE | Quantity |
|---|---|
| *N95 or equivalent respirators* | Government Financial Information |
| *Surgical or procedure masks* | |
| *Eye protection (including goggles and face shields)* | |
| *Gloves (pairs)* | |
| *Gowns* | |

## FINANCIAL IMPLICATIONS

- The acquisition of PPE supplies is being managed through the PHSA in consultation with the Ministry. The PPE-related costs, including possible inventory valuation adjustments that may required as a result of the year-end inventory audit review will not be available until after the close of the 2020/21 fiscal year-end and the external audit of PHSA's financial statements has been completed. This information will be publicly disclosed with the release of the Government's 2020/21 Public Accounts.

**Approved:**
April 26, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
April 28, 2021 – Gordon Cross obo Phillip Twyford, ADM, Finance and Corporate Services Division

[1] Internal Ministry of Health document dated April 12, 2021.
[2] N95/PPE Sub Working Group: Weekly Report, April 6, 2021.
[3] Ibid
[4] March 29, 2020 PHSA Supply Chain COVID-19 Dashboard.
[5] December 26, 2020 PHSA Supply Chain COVID-19 Dashboard.
[6] April 26, 2021 PHSA Supply Chain COVID-19 Dashboard
[7] Minister of Health Weekly PPE Update April 19, 2021.

# LEGISLATIVE SESSION - FACT SHEET

# UBC-YVR-WestJet COVID-19 Screening Study

## TOPIC

On November 27, 2020 the University of BC (UBC) and Providence Health Care launched the *UBC-YVR-WestJet COVID-19 Screening Study* at Vancouver International Airport (YVR) to determine the feasibility of enrolling domestic travel passengers and implementing a point-of-care test device to identify individuals who may be infectious for SARS-CoV-2 before departure. The project is sponsored by Providence Health Care, the Vancouver Airport Authority and WestJet.

## CURRENT SITUATION

UBC-YVR-WestJet COVID-19 Screening Study

- Phase 2 of the study screened 200 passengers between November 23, 2020 and December 17, 2020, using the Abbott PanBio COVID-19 AG Rapid Test. Of the 200 passengers screened at YVR, all rapid antigen tests were negative. All of the samples also tested negative on Polymerase chain reaction (PCR).
- On December 31, 2020, the UBC-YVR-WestJet Project Working Group released on interim report on completion of Phase 2, entitled: *An Approach to Screening for COVID-19 (SARS-CoV-2) at YVR*.
- The interim report provided the following summary:
    - We have successfully implemented point-of-care testing to identify potentially infectious departing travelers at YVR. The test itself consumes 15 to 20 minutes, which results in minimal disruption to the passenger's travel plans and to the airline.
    - All of the participants tested NEGATIVELY on the PanBio Assay, which was confirmed on standard PCR. Thus, even with some degree of uncertainty and the possibility of volunteer bias, the rate of SARS-CoV-2 infection in airline passengers is likely to be extremely low (<1%).
    - Mild symptoms which could be consistent with an upper respiratory tract infection did not discriminate between those with or without SARS-CoV-2 infection and thus a poor indicator of disease.
    - All of the passengers found the test experience acceptable and appreciated the rapidity of the results. The major concerns were the possibility of a false-positive that would deny them boarding and the rumors of high "failure" rate of the rapid antigen tests.
- Phase 3 is currently underway with the goal of enrolling an additional 700 passengers; there is no set end date yet, and they expect to reach their participant goal by end of February 2021.
- Phase 3 will evaluate oral secretions (collected using oral rinse) in addition to nasopharyngeal swabs for both rapid antigens testing and PCR testing.
- Phase 3 has expanded criteria to include those whose primary residence is not BC and those over the age of 80 years but less than 90 (Phase 2 was 19 to 80). In addition to registering for the study at airport check-in Phase 3 subjects will be able to register online when they book their flight.
- Subjects are excluded from the study if they had previously tested positive for COVID-19 within the past 90 days or could not provide written informed consent.
- 229 subjects were approached in Phase 2 when presenting at the check-in for their flight, and of those 200 (87%) met full eligibility criteria and provided informed consent. Of the subjects who refused to take the test, the most common concerns were fear of being denied boarding/not getting on the flight and concerns about receiving a false positive result.
- All Phase 2 passengers underwent a Nasopharyngeal swab evaluation using a rapid antigen test. Remnant samples from these tests were subjected to PCR testing (Roche) at an accredited provincial laboratory.
- YVR onsite testing is supervised by a registered nurse and administered by research coordinators. If the subject tests positive an onsite PCR test is conducted immediately by the registered nurse.
- Phase 1 of the study was used to determine the preferred rapid test. The Abbott PanBio COVID-19 Ag Rapid Test Device (approved by Health Canada October 5, 2020) was chosen.
- The Abbott PanBio COVID-19 Antigen rapid test devices being used were secured by the UBC-YVR-WestJet Project Working Group through Providence Health Care and are part of BC's allocation from Health Canada.

- The study has been registered on Clinical Trials website (https://clinicaltrials.gov/ct2/show/NCT04665193) and has been fully approved by the UBC/Providence Health Care Research Ethics Board (certificate # H20-03225).

COVID-19 Air Travel Working Group

- In September 2020 BC established the *COVID-19 Air Travel Working Group* to support *BC's Restart Plan* and safe travel when appropriate.
- The Working Group and sub-tables provide a forum to facilitate discussions between air industry stakeholders, the Province of BC, the Government of Canada, as well as Public Health Officials, to determine the necessary requirements to safely manage a staged reopening of air travel while mitigating the risks of COVID-19 transmission.
- The Working Group is jointly seeking solutions and monitoring the point-of-care testing research study being undertaken in the UBC-YVR-WestJet COVID-19 Screening Study at Vancouver International Airport, and also other research studies and pilots, including those at the Calgary International Airport, Toronto Pearson International Airport, and the Montreal-Trudeau International Airport.

## KEY FACTS

- The Government of Canada is prohibiting the entry of foreign nationals into Canada and requires all travellers entering Canada to quarantine for 14-days, and effective January 7, 2021, all air travellers 5 years of age or older are required to present a negative COVID-19 test result to the airline prior to boarding international flights bound for Canada.
- The BC Centre for Disease Control tracks potential domestic and international flight exposures with a BC origin or destination.[1] The Government of Canada provides similar information on a national level.[2]
- Vancouver International Airport reports that approximately 78% less domestic passengers enplaned or deplaned in November 2020 compared to November 2019. In November 2020, approximately 93% less transborder or international travelers enplaned or deplaned compared to November 2019.[3]
- Current Statistics Canada data reports that in October 2020, Canadian airlines carried 906,000 passengers on scheduled and charter services, down 86.3% from the same month in 2019.[4]

## FINANCIAL IMPLICATIONS

- N/A

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**Approved:**
January 27, 2021 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division

[1] http://www.bccdc.ca/health-info/diseases-conditions/covid-19/public-exposures
[2] https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/latest-travel-health-advice/exposure-flights-cruise-ships-mass-gatherings.html
[3] https://www.yvr.ca/-/media/yvr/documents/facts-sheets/2020/11-november/november-passenger.pdf
[4] https://www150.statcan.gc.ca/n1/en/daily-quotidien/201222/dq201222c-eng.pdf?st=NJRgo6X9

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# LEGISLATIVE SESSION - FACT SHEET

# 2019/20 Ministry of Health Annual Service Plan Report

## TOPIC

The *2019/20 Annual Service Plan Report* (ASPR) details the strategies and initiatives undertaken by the Ministry of Health toward achievement of the objectives set out in the *2019/20 – 2021/22 Service Plan*. The ASPR also reports on financial expenditures and major capital projects.

## CURRENT SITUATION

The Ministry's 2019/20 ASPR was tabled alongside Public Accounts on August 31, 2020.

## KEY FACTS

- The *Budget Transparency and Accountability Act* requires that all ministries produce an ASPR which is tabled with Public Accounts each year.
- The ASPR is intended to be a high-level document that compares the actual results for a given fiscal year with the expected performance measure results (targets) identified in the corresponding service plan.
- **The targets and results of the eight performance measures are summarized below using information published in the 2019/20 ASPR:**

| **Goal 1: Ensure a focus on service delivery areas requiring strategic repositioning.** | **2019/20 Target** | **2019/20 Actual** |
|---|---|---|
| **1.1 A primary care model that provides comprehensive, coordinated and integrated team-based care** | | |
| Number of Primary Care Networks operating or in implementation. | 25 | 39<br>Target exceeded as of end of quarter 4 |
| **1.2 Improved health outcomes and reduced hospitalizations for seniors through effective community services.** | | |
| Number of people with a chronic disease admitted to hospital per 100,000 people aged 75 years and older. | 3,010 | 2,817<br>Target exceeded as of end of quarter 2<br>*(Oct. 5, 2020 updated results not included in ASPR: 2,731 - Target exceeded as of end of quarter 4)* |
| **1.3 Timely access to appropriate surgical procedures.** | | |
| Surgeries in targeted priority areas completed. | 26,996[1] | 25,710<br>Target not met as of end of quarter 4[2] |
| **Goal 2: Support the health and well-being of British Columbians through the delivery of high-quality health care services.** | **2019/20 Target** | **2019/20 Actual** |
| **2.1 Effective population health, health promotion and illness and injury prevention services.** | | |

[1] Targets for this measure in the *Ministry of Health 2019/20 Service Plan* were adjusted up from those in the *2018/19 Service Plan* due to a miscalculation when PHSA targets were added. The 2019/20 target was correctly provided to health authorities at 26,996 surgeries in priority areas. The *2020/21 Ministry of Health Service Plan* corrected other miscalculated targets in the *2019/20 Service Plan* to be 27,300 (down from 28,160) for 2020/21; and 27,600 (down from 28,660) for 2021/22.

[2] Data shows that actual surgeries of 25,710 fell short of the 2019/20 target of26,996 due to the difficult decision to stop and postpone non-urgent, scheduled surgeries following the COVID-19 outbreak toward the end of the fiscal year

| | | |
|---|---|---|
| Percent of communities that have completed healthy living strategic plans. | 68% | 71%<br>Target exceeded as of end of quarter 3<br>*(Oct. 5, 2020 updated results not included in ASPR: 74% - Target exceeded as of end of quarter 4)* |
| **2.2 Improved health outcomes and reduced hospitalizations for those with mental health and substance use issues through effective community services.** | | |
| Percent of people admitted for mental illness and substance use who are readmitted within 30 days. | 14.2% | 14.2%<br>Target met as of end of quarter 2<br>*(Oct. 5, 2020 updated results not included in ASPR: 14.4% - Target not met as of end of quarter 4)* |
| **2.3 Continued improvement of other key primary and community care services.** | | |
| Potentially inappropriate use of antipsychotics in long-term care. | 23% | 24.5%<br>Target not met as of end of quarter 2<br>*(Oct. 5, 2020 updated results not included in ASPR: 24.7% - Target not met as of end of quarter 4)* |
| **2.4 Continued improvement of hospital services.** | | |
| Rate of new *C. difficile* cases associated with a reporting facility per 10,000 inpatient days. | 3.3 | 3.3<br>Target met as of end of quarter 1<br>*(Oct. 5, 2020 updated results not included in ASPR: 3.2 -Target met as of end of quarter 4)* |
| **Goal 3: Deliver an innovative and sustainable public healthcare system.** | **2019[3] Target** | **2019 Actual** |
| **3.1 Effective health sector resources and approaches to funding** | | |
| Nursing and allied professionals overtime hours as a percent of productive hours | 3.8% | 4.6%<br>Target not met as of end of 2019[4] |

(Data included in the Actual column in this table matches what was published in the *2019/20 Annual Service Plan Report* on August 31, 2020.)

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

February 4, 2021: Martin Wright, Health Sector Information, Analysis & Reporting Division
March 5, 2021: Antje Helmuth, Strategy Management Office, Deputy Minister's Office
March 5, 2021: Holly Moulton, Executive Operations, Deputy Minister's Office

[3] This measure is on a calendar-year basis rather than fiscal year
[4] The 2019 target has not been met largely as a result of the demand for nursing and allied health professionals exceeding available supply

# LEGISLATIVE SESSION - FACT SHEET

# 2020 Minister of Health Mandate Letter

## TOPIC

The Minister of Health receives direction from the Premier through the Minister's Mandate Letter. The Minister is accountable for achieving the priorities contained in the Mandate Letter.

## CURRENT SITUATION

The Mandate Letter was issued to the Minister of Health on November 26, 2020.

## KEY FACTS

The Mandate Letter articulates government's five foundational principles made to British Columbians and reflects twenty-one priorities specific to the Ministry of Health.

The five government foundational principles are:

1) Putting People first – enhancing the public services people rely on and working to make life more affordable for everyone.
2) Lasting and meaningful reconciliation – remain focused on creating opportunities for Indigenous peoples to be full partners in our economy and providing a clear and sustainable path for everyone to work toward lasting reconciliation.
3) Equity and anti-racism – ensure increased Indigenous, Black and People of Colour (IBPOC) representation within the public service, including in government appointments, and to review all decisions through a Gender-Based Analysis Plus (GBA+) lens.
4) A better future through fighting climate change – continue to achieve CleanBC's goals
5) A strong, sustainable economy that works for everyone – support British Columbians through the pandemic and the economic recovery by investing in the health care, getting people back to work, helping businesses and communities, and building the clean innovative economy of the future.

The commitments specific to the Ministry of Health are:

1) Continue your work with the Provincial Health Officer to control and eliminate the spread of COVID-19 in B.C., keep people safe and protect seniors, and prepare our province for any future pandemic, with state-of-the-art testing, contact tracing, and hospital management procedures and technology.
2) Ensure the COVID-19 fall and winter preparedness plan is implemented successfully, including providing at least 2 million doses of flu vaccines, expanding e-health and tele-health, and providing a new Hospital at Home program so patients can safe care while in the comfort of their homes.
3) Once a vaccine is approved and available, provide free COVID-19 vaccinations to every British Columbian.
4) Move forward a staffing retention strategy that provides workers in long-term care and assisted living with "levelled up wages" even after the pandemic ends, and restore provincial standards for wages, benefits, and working conditions.
5) Work toward eliminating multi-bed rooms in health authority-owned long-term care facilities, giving seniors more dignity.
6) Support delivery of better care to seniors by private operators of long-term care homes by making them more accountable for the public funding they receive.
7) Improve and expand publicly funded home care to provide better care and help with daily living so that people can stay in their own homes for as long as is safely possible, receiving care from a more stable group of care aides.
8) Deliver more Urgent and Primary Care Centres and additional Primary Care Networks across B.C.
9) Work with rural and Indigenous communities to ensure the success of our rural collaborative framework to deliver more immediate and culturally safe care closer to home.
10) Build and modernize hospitals across B.C.

11) Where possible and appropriate, transition long-term care aides, housekeeping, and dietary hospital workers back into the public health care system.
12) Seek to further reduce wait times by optimizing surgical and diagnostic space and teams, and add additional MRI scanners where they are needed most, so B.C. can keep pace with the demand for new surgeries and diagnostic scans.
13) Make B.C. a leader in the full continuum of cancer care by launching a 10-year cancer action plan.
14) Implement a comprehensive health care human resources strategy, expanding training in all fields of health care and improving the province's credential recognition process and licensing so that people trained in other countries can more quickly and easily provide their skills and knowledge here in B.C.
15) Make prescription contraception free for all.
16) Fight for a national pharmacare program while enhancing Fair Pharmacare by continually reviewing cost thresholds and drug eligibility with the goal of bringing the cost of prescription drugs down.
17) With support from the Parliamentary Secretary for Anti-Racism Initiatives, draw from the work of the independent investigation into systemic Indigenous-specific racism in health care in B.C. to address systemic racism in the health care system, including by leading work with health employers and unions to prioritize the hiring of a health care workforce that better represents the diverse communities it serves.
18) Support the Minister of Advanced Education and Skills Training to launch B.C.'s second medical school to expand our health care workforce.
19) Support the work of the Minister of Mental Health and Addictions to improve B.C.'s response to the opioid crisis across the full continuum of care: prevention, harm reduction, safe prescription medications, treatment and recovery, including transferring the oversight of recovery homes and other private treatment providers to the Ministry of Mental Health and Addictions.
20) Support the work of the Minister of Mental Health and Addictions to provide an increased level of support – including more access to nurses and psychiatrists – for B.C.'s most vulnerable by developing Complex Care housing.
21) Support the work of the Attorney General and Minister responsible for Housing to address the needs of people experiencing homelessness, including those living in encampments.

These priorities are expected to be reflected in the *2020/21 Ministry of Health Service Plan*, and will be reported against future *Ministry of Health Annual Service Plan Reports*.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
February 18, 2021: Antje Helmuth, Strategy Management Office, Deputy Minister's Office
February 18, 2021: Holly Moulton, Executive Operations, Deputy Minister's Office

# LEGISLATIVE SESSION - FACT SHEET

# 2020/21 Ministry of Health Service Plan Measures

## TOPIC

Outlining the nine *2020/21 Ministry of Health Service Plan* performance measures and targets, along with year-to-date performance results.

## CURRENT SITUATION

The *2020/21 Ministry Service Plan* was released publicly on Budget Day, February 18, 2020. The 2021/22 service plan is currently in development.

## KEY FACTS

1.1 *Number of Primary Care Networks (PCNs) operating or in implementation:* Tracks cumulative implementation of PCNs across the province.

| Baseline (2016/17)[1] | 2020/21 Target | 2020/21 Actual | Target Met |
|---|---|---|---|
| 0 | 45 | 47 | Yes |

Results to date show that the Ministry has met its target as of February 2021, with an additional 6 PCN service plans to be approved before the end of 2020/21 fiscal, for a total of 53.

1.2a *Average direct care hours per resident day across all health authorities:* NEW for 2020/21. Tracks the average direct care hours per resident day 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. Target is for each health authority to reach 3.36 HPRD, on average by 2020/21.

| Baseline (2016/17)[2] | 2020/21 Target | 2020/21 Q3 Forecast | Target Met |
|---|---|---|---|
| 3.11 | 3.36 | 3.51 | Yes |

In 2020/21 all 5 health authorities were funded to meet the target of 3.36 HPRD, on average, and Q3 HPRD results show all 5 health authorities on track to meet or exceed this target, across their long-term care facilities (based on forecast of total direct care hours to be delivered and forecast actual resident occupancy).

1.2b *Potentially inappropriate use of antipsychotics in long-term care*: Identifies % of long-term care residents taking antipsychotics without psychosis diagnosis. Antipsychotics are sometimes used to manage behaviours associated with dementia. Use without psychosis diagnosis may compromise safety and care quality.

| Baseline (2017/18)[3] | 2020/21 Target | 2020/21 Actual | Target Met |
|---|---|---|---|
| 25.4% | 21% | 25.0% (Q1) | No |

Results to date show that the Ministry has not met its target.

1.2c *Number of people with a chronic disease admitted to hospital per 100,000 people aged 75 years and older:* Tracks hospitalization rates for those 75 years and older, with select chronic diseases (asthma, COPD, heart disease, diabetes), that can be prevented or reduced with appropriate primary care.

| Baseline (2016/17)[4] | 2020/21 Target | 2020/21 Actual | Target Met |
|---|---|---|---|
| 3,357 | 2,955 | 2,496 (Q1) | Yes |

Results to date show that the Ministry has met its target.

1.3 *Percent of people admitted for mental illness and substance use who are readmitted within 30 days:* The measure focuses on effectiveness of community-based supports to help persons with mental

[1] Data Source: Ministry of Health
[2] Data Source: Ministry of Health
[3] Data Source: Canadian Institute for Health Information
[4] Data Source: Discharge Abstract Data

illness and/or substance use issues receive appropriate and accessible care and avoid hospital readmission.

| Baseline (2016/17)[5] | 2020/21 Target | 2020/21 Actual | Target Met |
|---|---|---|---|
| 14.7% | 14.1% | 15.4% (Q1) | No |

Results to date show that the Ministry has not met its target.

1.4 *Surgeries in targeted priority areas completed:* The measure tracks the efforts to "catch up" and "keep up" volumes in the priority areas of total hip, knee and dental surgeries.

| Baseline (2016/17)[6] | 2020/21 Target[1] | 2020/21 Actual | Target Met |
|---|---|---|---|
| 20,541 | 27,300 | 15,451 (P10 YTD) | No |

[1] The 2019/20 Service Plan incorrectly stated the 2019/20 target due to a miscalculation when the PHSA targets were added to this measure. The 2019/20 target was correctly provided to health authorities and corrected in the 2020/21 Service Plan. The 2020/21 target was also adjusted to reflect this.

Year-to-date results from April 1, 2020, to January 7, 2021, show that the Ministry has not met its target.

2.1 *Percent of communities that have completed healthy living strategic plans:* The measure focuses on the proportion of communities across the province that have developed healthy living strategic plans. ("Communities" includes cities, districts, municipalities, towns, townships, and villages.)

| Baseline (2017/18)[7] | 2020/21 Target | 2020/21 Actual | Target Met |
|---|---|---|---|
| 62% | 70% | 74% (Q1) | Yes |

Results to date show that the Ministry has met its target.

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 therefore improves quality of care and patient safety, protecting patients and healthcare providers.

| Baseline (2017/18)[8] | 2020/21 Target | 2020/21 Actual | Target Met | 2019/20 Actual |
|---|---|---|---|---|
| 3.8 | 3.1 | n/a | TBD | 3.2 |

Results to date are not available to indicate if the Ministry has met its target. As such, results for 2019/20 are included here. The 2019/20 target was met as of the end of Q4 2019/20.

3.1 *Nursing and allied professionals overtime hours as a percent of productive hours:* The measure compares overtime amounts to overall time worked by unionized professional nurses (RNs and RPNs) and allied professionals (occupational therapists, physiotherapists, medical techs, social workers, pharmacists, radiation techs).

| Baseline (2016)[9] | 2020 Target | 2020 Actual | Target Met |
|---|---|---|---|
| 3.8% | 3.8% | 4.1% (Q3) | No |

Results to date show that the Ministry has not met its target.

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

February 24, 2021 - Martin Wright, Health Sector Information, Analysis & Reporting Division
March 17, 2021 - Antje Helmuth, Strategy Management Office, Deputy Minister's Office
March 17, 2021 - Kerri Harrison- obo Philip Twyford, ADM, Finance and Corporate Services Division
March 18, 2021 - Holly Moulton, Executive Operations, Deputy Minister's Office

[5] Data Source: Discharge Abstract Database
[6] Data Source: Surgical Patient Registry (Site ID 200)
[7] Data Source: Health Authority annual community survey
[8] Data Source: Provincial Infection Control Network of BC (PICNet)
[9] Data Source: Health Sector Compensation Information System

# LEGISLATIVE SESSION - FACT SHEET

# 2020/21 Provincial Health Services Authority Mandate Letter

## TOPIC

The Provincial Health Services Authority (PHSA) mandate letter articulates high-level direction for the fiscal year that forms the basis for planning and priority setting. PHSA receives its mandate letter annually from the Ministry of Health.

## CURRENT SITUATION

The *2020/21 PHSA Mandate Letter* was sent to PHSA for board member signature on February 19, 2020. The signed mandate letter was posted by PHSA to their website in July 2020.

## KEY FACTS

The *2020/21 Provincial Health Services Authority Mandate Letter* provides direction to PHSA on key Government priorities, including advancing GBA+, a low-carbon economy, and reconciliation with Indigenous Peoples, as well as developing and maintaining effective and efficient working relationships with regional health authorities (RHAs) and the First Nations Health Authority while ensuring patients are treated with respect and compassion. Specific priorities include:

1. **Health Sector Strategic Priorities**
   Continued collaboration with the Ministry and RHAs to:
   - link provincial clinical policy, health services, commercial and digital/IMIT services to the Team-Based Primary Care Strategy; and to support improved care for seniors while ensuring linkages to provincial specialized services and programs;
   - improve team-based care for patients accessing Mental Health & Substance Use Services through primary care and specialized services; support the Ministry of Mental Health and Addictions with implementation of *Pathway to Hope* in 2020/21; and support the continued response to the opioid overdose public health emergency;
   - improve timely access and reduce wait times for scheduled surgery and MRIs; and
   - proactively plan and manage health human resources; and, aligned with the passing of Bill 47, the *Health Sector Statutes Repeal Act*, ensure stability and respect for workers, and continuity of care for patients and clients.

2. **Provincial Health Service Improvement Initiatives**
   <u>Provincial Clinical Policy and Clinical Coordination</u>
   - Collaboratively develop, implement, monitor, evaluate, and report on provincial clinical policy to be applied across the health sector.

   <u>Population Health, Health Promotion and Prevention</u>
   - Continue to strengthen public health, health promotion, and illness and injury prevention services; and ensure that the BC Centre for Disease Control provides diagnostic and treatment services for diseases of public importance.

   <u>Primary and Community Care</u>
   - Ensure Perinatal Services BC works collaboratively with RHAs to sustain, stabilize, and expand access to team-based maternity services, including low-risk maternity care, and to continue to improve coordination of clinical chronic pain management services.

   <u>BC Cancer</u>
   - Continue to improve cancer services across the continuum of cancer care, including a focus on Indigenous Peoples through the Indigenous Cancer Strategy.

Diagnostic, Laboratory and Pharmaceutical Services

- Collaborate with RHAs to increase integrated planning and service coordination based on the Ministry's approved plans for diagnostic imaging services, and pathology and laboratory medicine; and collaborate with RHAs and the Ministry's Pharmaceutical Services Division to improve services and access.
- Work with the Ministry Pharmaceutical Division and RHAs to improve pharmacy services and ensure timely access to appropriate and cost-effective services through increased cross-sector planning and coordination based on a coordinated approach for evidence-informed medicine review, listing, planning and budgeting.

Hospital Services

- In partnership with RHAs, ensure appropriate supply and distribution of paramedic and transport services; and provide services through BC Children's and Women's that ensure clinical management, monitoring, analysis, and reporting to the Board and Ministry.

**3. Operational Management Initiatives**

Health Human Resource Management

- Ensure effective human resource management systems, and ensure staffing, including contracted services, provides stable, consistent high-quality care.
- Ensure effective engagement and relationships with physicians, and with health sector unions, as well as compliance with collective agreements.
- Ensure action consistent with Workplace Violence Prevention Framework and Policy and implement the National Standard for Psychological Health and Safety for workers.

Digital/Information Management and Information Technology, and Infrastructure Initiatives

- Develop a multi-year investment strategy proposal with the Ministry's Finance division based on the Ministry's approved digital IMIT priorities, and ensure that projects align with the provincial priorities and strategies plan.

Commercial Services Initiatives

- Working with RHAs, follow through on implementation based on the outcomes of the 2019/20 Leadership Council review, and Ministry approval of both the focus and a paced plan for sequencing consolidation.

Improvement of Operational Governance, Leadership, Management, Policy, Funding, Monitoring and Reporting and Evaluation

- Manage within budget allocation; demonstrate effective cost management and reporting; and continuously improve productivity.
- Support initiatives increasing use of research-evidence, including the Strategy for Patient-Oriented Research Support Unit and Academic Health Sciences Network, and the Ministry's *Putting Our Minds Together: Research and Knowledge Management Strategy.*
- Continue to improve performance management processes and reporting through to the Board from the Executive Team, including ensuring Executive provide regular reporting through to the Ministry and Health Authority Bilateral Review Process.
- Ensure effective review and continuous improvement of governance practices.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
March 16, 2021 - Antje Helmuth, Strategy Management Office
March 16, 2021 - Holly Moulton, Deputy Minister's Office

# LEGISLATIVE SESSION - FACT SHEET

## 2020/21 Provincial Health Services Authority Service Plan Measures

### TOPIC

Outlining the fourteen 2020/21 Provincial Health Services Authority (PHSA) Service Plan performance measures, 2019/20 Actuals, and Targets as indicated in PHSA's 2020/21 Service Plan.

### CURRENT SITUATION

PHSA posted its 2020/21 Service Plan in April 2021.

### KEY FACTS

- PHSA's 2020/21 Service Plan contains 14 performance measure tables, different from the 2020/21 regional health authority service plans that contain 7.
- Standardized text developed by the Health Services Division points to Surgical Renewal in place of the performance measure tables for "Surgeries Completed in Priority Areas" and "MRI exams in targeted priority areas completed" that were used previously.
- One performance measure is new for 2020/21: #3.4 "Number of virtual health visits for PHSA programs," which shows the increase or decrease in access to services without geographic or physical barriers.
- One performance measure table was removed: "Number of clinical staff and physician participants in emergency preparedness training and exercises."
- The Ministry Health Sector Analysis and Reporting Division (HSIARD) indicates it has data only for measures #1.2 (dialysis), #2.1 (vaccinations), and #3.5 (nursing overtime); therefore, HSIARD's data verification is limited to 3 of 14 measures. Remaining measures are set by PHSA and verified by their data sources.
- The Ministry's Finance Division is able to verify measure #3.1.

| Performance Measure | 2018/19 Baseline | 2019/20 Actuals | 2020/21 Target | 2021/22 Target | 2022/23 Target |
|---|---|---|---|---|---|
| 1.1 Number of unique community paramedic patients' visits[1] | 14,889 | 18,661 | 18,000[2] | 24,000[2] | 30,000 |
| **Performance Measure** | **2016/17 Baseline** | **2019/20 Actuals** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 1.2 % of dialysis patients on independent dialysis[3] | 31.2%[4] | 29.8% | 32.5% | 32.5% | 31.5% |
| **Performance Measure** | **2017/18 Baseline** | **2019/20 Actuals** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 1.4 % of ischemic stroke patients who receive Plasminogen Activator (tPA)[5] | 13.6% | TBD[6] | 14.5%[2] | 15.0%[2] | 15.5% |
| **Performance Measure** | **2017/18 Baseline** | **2019/20 Actuals** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 1.6 Formalized agreements with each of MNBC, BCAAFC and FNHA signed off by all signatories including PHSA's board of directors[7] | 0 | 0 | 1 | 2[2] | 1 |
| **Performance Measure** | **2017 Baseline** | **2019 Actuals** | **2020 Target** | **2021 Target** | **2022 Target** |
| 2.1 % of children with complete vaccination by seven years of age[8] | 68% | 69% | 75% | 77% | 79% |
| **Performance Measure** | **2019/20 Baseline** | | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 2.2 Number of opioid agonist therapy (OAT) initiations by Correctional Health services[9] | 1,578 | | 950 | 1,000 | 700 |

[1] Data Source: BC Emergency Health Services, PHSA
[2] Target has been adjusted upward from PHSA's 2019/20 Service Plan
[3] Data Source: BC Renal, PHSA
[4] Reflects HSIAR data review June 30, 2020, showing an upward adjustment to the Baseline from 30.8 in PHSA's 2019/20 Service Plan
[5] Data Source: Discharge Abstract Database
[6] PHSA Service Plan notes data will be available in Spring 2021
[7] Data Source: Indigenous Health, PHSA. MNBC, BCAAFA, FNHA
[8] Data Source: BC Centre for Disease Control, PHSA; VCHA; B.C. Ministry of Education; this measure is based on calendar year
[9] Data Source: Correctional Health Services – Primary Assessment and Care, PHSA. Note: OAT data for Regional Forensic Psychiatric Clinics not available

| Performance Measure | 2017/18 Baseline | 2019/20 Forecast | 2020/21 Target | 2021/22 Target | 2022/23 Target |
|---|---|---|---|---|---|
| 2.3 % of patients with improved mental health status between admit and discharge[10] | 72% | N/A[11] | ≥77% | ≥79% | ≥79% |
| **Performance Measure** | **2017/18 Baseline** | **2019/20 Actuals** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 2.4 % of patients treated with radiation therapy within four weeks of "Ready To Treat" status[12] | 90% | 89% | >90% | >90% | >90% |
| **Performance Measure** | **2017/18 Baseline** | **2019/20 Actuals** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 3.1 Financial surplus/deficit – variance from budget at fiscal year-end[13] | Balanced budget | Target met | Balanced budget | Balanced budget | Balanced budget |
| **Performance Measure** | **2017/18 Baseline** | **2019/20 Forecast** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 3.2 Cumulative % of total scheduled Clinical and Systems Transformation (CST) deployments[14] | 0% | 12% | 69% | 100% | 100% |
| **Performance Measure** | **2017/18 Baseline** | **2019/20 Actuals** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 3.3 % order fulfillment rate by PHSA Supply Chain for clinical orders[15] | 96.6% | 97.2% | ≥95% | ≥95% | ≥96% |
| **Performance Measure** | **2019/20 Forecast** | | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 3.4 Number of virtual health visits for PHSA programs[16] | 13,750 | | 16,500 | 116,631[17] | 122,185 |
| **Performance Measure** | **2016 Baseline** | **2019 Actuals** | **2020 Target** | **2021 Target** | **2022 Target** |
| 3.5 Nursing and allied professionals overtime hours as a % of productive hours[18] | 2.5% | 3.0% | 2.8% | 2.8% | 2.8% |
| **Performance Measure** | **2017/18 Baseline** | **2019/20 Forecast** | **2020/21 Target** | **2021/22 Target** | **2022/23 Target** |
| 3.6 % of selected PHSA data and holdings with processes in place for expedited data access[19] | 0% | 12.5% | 50% | 100% | N/A[20] |

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

May 14, 2021 - Martin Wright, ADM, Health Sector Information, Analysis and Planning and Reporting Division
May 14, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
May 18, 2021 - Antje Helmuth, Strategy Management Office, Deputy Minister's Office
May 20, 2021 - Holly Moulton, Executive Operations, Deputy Minister's Office

[10] Data Source: Burnaby Centre for Mental Health and Addiction, HoNOS Instrument
[11] Q4 2019/20 data is not available due to disruption in data capture during the transition to CST Cerner and shifting priority do the COVID-19 response
[12] Data Source: BC Cancer, PHSA
[13] Data Source: PHSA
[14] Data Source: Information Management/Information Technology Services (IMITS), PHSA
[15] Data Source: Supply Chain, PHSA
[16] Data Source: Office of Virtual Health, PHSA; virtual health visits are estimated
[17] Based on projected impact of COVID-19, virtual health use is forecasted to increase
[18] Data Source: Health Sector Compensation Information System and HEABC; this measure is based on calendar year.
[19] Data Source: Research, PHSA. Data holdings include Cardiac Services BC Registry, BC Perinatal Registry, BC Cancer Registry, PROMIS – Renal, PROMIS – Transplant, Surgical Patient Registry, PHSA Enterprise Data Warehouse and Provincial Laboratory Medicine Services; this measure has been updated from the 2019/20 Service Plan published by PHSA. Previously "data and holdings" was used but this is incorrect in referring to the data holdings.
[20] 20/21 SP Discussion for the measure indicates that the target percent is projected to be complete, therefore a target for 2022/23 is indicated as not applicable.

# LEGISLATIVE SESSION - FACT SHEET

# 2020/21 Regional Health Authority Mandate Letter

## TOPIC

Regional health authority mandate letters articulate high-level direction for a fiscal year that forms the basis for planning and priority setting by health authorities. All five regional health authorities receive the same letter. A separate letter is sent to Provincial Health Services Authority (PHSA). Mandate letters are issued annually by the Ministry of Health.

## CURRENT SITUATION

The *2020/21* health authority mandate letters were sent to the health authorities for board member signature on February 19, 2020, prior to posting on their websites.

## KEY FACTS

The 2020/21 regional health authority mandate letters provide direction to health authorities on key government priorities, including advancing GBA+, a low-carbon economy, and reconciliation with Indigenous Peoples, as well as developing and maintaining working relationships with the First Nations Health Authority while ensuring patients are treated with respect and compassion. Other priorities include:

1. **Health Sector Strategic Priorities**
   - Continued collaboration with the Ministry to:
     - implement integrated team-based primary care through urgent and primary care centres, full service primary care clinics, patient medical homes, and community health centres, including First Nations led primary care clinics;
     - improve care for seniors with complex medical conditions by developing integrated, team and community-based health services, and continuing to improve long-term care services with a focus on achieving an average of 3.36 direct care hours per resident day by end of 2020/21.
     - improve team-based care for patients accessing Mental Health & Substance Use Services through both primary care and specialized services; support the Ministry of Mental Health and Addictions with implementation of *Pathway to Hope* in 2020/21; and support the response to the opioid overdose public health emergency;
     - improve timely access and reduce wait times for scheduled surgery and MRIs; and
     - Proactively plan and manage health human resources; and, aligned with the passing of Bill 47, the *Health Sector Statutes Repeal Act*, ensure stability and respect for workers, and patient and client continuity of care.

2. **Regional Health Service Improvement Initiatives**

   Population Health, Health Promotion and Prevention
   - Sustain and continue to strengthen the delivery of public health, health promotion, and illness and injury prevention initiatives and services to promote population health and reduce long-term health system costs.

   Primary and Community Care
   - Work with Perinatal Services BC to sustain and, where appropriate, expand team-based maternity service, including low risk maternity care, and collaborate with PHSA to continue to improve clinical chronic pain management services.

   Diagnostic, Laboratory and Pharmaceutical Services
   - Work with PHSA to implement cross-sector planning and coordination based on the Ministry's approved plans for diagnostic services and for pathology and laboratory medicine.
   - Work with the Ministry Pharmaceutical Division and PHSA to improve pharmacy services and ensure timely access to appropriate and cost-effective services through increased cross-sector planning and coordination based on a coordinated approach for evidence-informed medicine review, listing, planning and budgeting.

Hospital Services

- Provide high-quality services that meet population needs, ensuring clinical management, oversight, monitoring, analysis, follow-up, and routine reporting to Board and Ministry.

Provincial Clinical Services

- Ensure effective referral pathways and service linkages for patients between regional health services and provincial specialized services and programs provided by PHSA.

**3. Operational Management Initiatives**

Health Human Resource Management

- Ensure effective health human resource management systems, including for any contracted services, provide stable, consistent high-quality care.
- Ensure effective engagement and relationships with physicians, and with health sector unions, as well as compliance with collective agreements.
- Ensure action consistent with Workplace Violence Prevention Framework and Policy, and implement the National Standard for Psychological Health and Safety for workers.

Digital/Information Management and Information Technology, and Infrastructure Initiatives

- Work with PHSA to develop a multi-year investment strategy proposal with the Ministry's Finance division based on Ministry approved digital IMIT priorities, begin to prioritize projects, and ensure a coordinated approach for project approval.

Commercial Services Initiatives

- Work with PHSA to follow through on implementation based on the outcome of the 2019/20 Leadership Council review, and Ministry approval of both the focus and a paced plan for sequencing the consolidation.

Improvement of Operational Governance, Leadership, Management, Policy, Funding, Monitoring and Reporting and Evaluation

- Manage within budget allocation; demonstrate effective cost management and reporting; and continuously improve productivity and efficiency while maintaining strong focus on quality service attributes and health outcomes.
- Support use of evidence-research, including the Strategy for Patient-Oriented Research Support Unit and Academic Health Sciences Network, and the Ministry's *Putting Our Minds Together: Research and Knowledge Management Strategy.*
- Continue to improve performance management processes and reporting through to the Board from Executive to ensure oversight, including ensuring Executive provide regular reporting through to the Ministry and Health Authority Bilateral Review Process.
- Ensure review and continuous improvement of health authority governance practices.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
March 16, 2021 - Antje Helmuth, Strategy Management Office
March 16, 2021 - Holly Moulton, Deputy Minister's Office

# LEGISLATIVE SESSION - FACT SHEET

# 2020/21 Regional Health Authority Service Plan Measures

## TOPIC

Outlining the eight 2020/21 Regional Health Authority Service Plan performance measures, targets, and the year-to-date performance results.

## CURRENT SITUATION

All regional health authorities are currently posting their 2020/21 Service Plans to their websites.

## KEY FACTS

1. *Number of people with a chronic disease admitted to hospital per 100,000 people aged 75 years and over:* Tracks hospitalization rates for those 75 years and older, with select chronic diseases (asthma, COPD, heart disease, diabetes), that can be prevented or reduced with appropriate primary care.

| Baseline (2016/17)[1] | 2020/21 Targets | 2020/21 Actual | Target Met |
|---|---|---|---|
| FHA: 3,716 | FHA: 3,106 | FHA: 2,634 | FHA: Yes |
| IHA: 3,974 | IHA: 3,374 | IHA: 3,012 | IHA: Yes |
| NHA: 4,907 | NHA: 4,526 | NHA: 4,206 | NHA: Yes |
| VCHA: 2,620 | VCHA: 2,282 | VCHA: 1,900 | VCHA: Yes |
| VIHA: 2,753 | VIHA: 2,481 | VIHA: 2,133 | VIHA: Yes |

Available results show that FHA, IHA, NHA, VCHA and VIHA are meeting their targets as of 2020/21 Q1.

2. *Percent of people admitted for mental illness and substance use who are readmitted within 30 days:* The measure focuses on effectiveness of community-based supports to help persons with mental illness and/or substance use issues receive appropriate and accessible care and avoid hospital readmission.

| Baseline (2016/17)[2] | 2020/21 Targets | 2020/21 Actual | Target Met |
|---|---|---|---|
| FHA: 13.5% | FHA: 12.5% | FHA: 16.6% | FHA: No |
| IHA: 15.7% | IHA: 13.3% | IHA: 15.2% | IHA: No |
| NHA: 10.1% | NHA: 10.6% | NHA: 8.9% | NHA: Yes |
| VCHA: 15.1% | VCHA: 13.1% | VCHA: 15.0% | VCHA: No |
| VIHA[3]: 12.5% | VIHA: 12.4% | VIHA: 13.1% | VIHA: No |

Available results show that NHA is meeting its target as of 2020/21 Q1.

3. *Surgeries in targeted priority areas completed:* The measure tracks the efforts to "catch up" and "keep up" volumes in the priority areas of total hip and knee replacements and dental surgeries.

| | % of postponed surgeries completed as of late 2020 |
|---|---|
| Given the unprecedented impacts of COVID-19, health authorities were advised to replace the performance measure for surgeries with wording developed by the Ministry to reflect the surgical renewal strategy. | FHA: 89%<br>IHA: 93%<br>NHA: 89%<br>VCHA: 88%<br>VIHA: 94% |

4. *Percent of communities that have completed healthy living strategic plans:* "Communities" includes cities, districts, municipalities, towns, townships, and villages. The measure focuses on the proportion of communities within each health authority that have developed healthy living strategic plans.

| Baseline (2017/18)[4] | 2020/21 Targets | 2020/21 Actual | Target Met |
|---|---|---|---|
| FHA: 85% | FHA: 90% | FHA: 85% | FHA: No |
| IHA: 58% | IHA: 63% | IHA: 78% | IHA: Yes |
| NHA: 15% | NHA: 75% | NHA: 66% | NHA: No |
| VCHA: 71% | VCHA: 93% | VCHA: 93% | VCHA: Yes |
| VIHA: 53% | VIHA: 56% | VIHA: 61% | VIHA: Yes |

Available results show that IHA, VCHA and VIHA are meeting their targets as of 2020/21 Q1.

[1] Data Source: Discharge Abstract Database, Health Sector Information, Analysis and Reporting Division, Ministry of Health.
[2] Data Source: Discharge Abstract Database, Hospital, Health Sector Information, Analysis and Reporting Division, Ministry of Health.
[3] VIHA baseline year is 2017/18
[4] Data Source: Health Authority Annual Community Survey, Population and Public Health Division, Ministry of Health.

5. *Nursing and allied professionals overtime hours as a percent of productive hours:* Compares overtime amounts to overall time worked by unionized professional nurses (RNs and RPNs) and allied professionals (occupational therapists, physiotherapists, medical techs, social workers, pharmacists, radiation techs).

| Baseline (2016)[5] | 2020 Targets | 2020 Actual | Target Met |
|---|---|---|---|
| FHA: 3.9% | FHA: <=3.9% | FHA: 4.2% | FHA: No |
| IHA: 3.8% | IHA: <=3.8% | IHA: 4.5% | IHA: No |
| NHA: 6.6% | NHA: <=6.6% | NHA: 7.2% | NHA: No |
| VCHA: 3.6% | VCHA: <=3.6% | VCHA: 3.8% | VCHA: No |
| VIHA: 3.9% | VIHA: <=3.9% | VIHA: 3.9% | VIHA: Yes |

Available results show that VIHA is meeting its target as of 2020 Q3. The Ministry will continue to invest in strategies to increase workforce supply and prioritize actions that reduce barriers to employment, enhance education and training opportunities, optimize the role and scope of health professionals.

6. *Potentially inappropriate use of antipsychotics in long-term care*: Identifies % of long-term care residents taking antipsychotics without psychosis diagnosis. Antipsychotics are sometimes used to manage behaviours associated with dementia. Use without psychosis diagnosis may compromise safety and care quality.

| Baseline (2017/18)[6] | 2020/21 Targets | 2020/21 Actual | Target Met |
|---|---|---|---|
| FHA: 22.8% | FHA: 19.0% | FHA: 21.8% | FHA: No |
| IHA: 25.8% | IHA: 22.5% | IHA: 25.1% | IHA: No |
| NHA: 32.3% | NHA: 26.0% | NHA: 37.7% | NHA: No |
| VCHA: 26.9% | VCHA: 22.5% | VCHA: 26.4% | VCHA: No |
| VIHA: 26.4% | VIHA: 22.5% | VIHA: 26.2% | VIHA: No |

Available results show that targets are not being met as of 2020/21 Q1.

7. *Rate of new C. difficile cases associated with a reporting facility per 10,000 inpatient days:* Actively monitoring *C. difficile* infections in acute care facilities, and developing evidence-based prevention and control guidelines, helps reduce such infections and therefore improves quality of care and patient safety, protecting patients and healthcare providers.

| Baseline (2017/18)[7] | 2020/21 Targets | 2020/21 Actual | Target Met | 2019/20 Actual |
|---|---|---|---|---|
| FHA: 3.4 | FHA: 3.1 | FHA: TBD | FHA: TBD | IHA: 3.5 |
| IHA: 5.7 | IHA: 3.1 | IHA: TBD | IHA: TBD | FHA: 3.4 |
| NHA: 2.9 | NHA: 3.1 | NHA: TBD | NHA: TBD | VCHA: 3.2 |
| VCHA: 3.4 | VCHA: 3.1 | VCHA: TBD | VCHA: TBD | VIHA: 2.6 |
| VIHA: 3.6 | VIHA: 3.1 | VIHA: TBD | VIHA: TBD | NHA: 2.8 |

Results for 2020/21 are not yet available. As such, included here are Actuals for 2019/20. Vancouver Coastal, Island, and Northern met their targets for 2019/20.

8. *Average direct care hours per resident day (HPRD) across the health authority:* New for 2020/21. Identifies the average direct care hours per resident day across all long-term care facilities in the health authority and reflects the government's commitment and efforts 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)[8] | 2020/21 Targets | 2020/21 Q3 Forecast | Target Met |
|---|---|---|---|
| FHA: 3.05 | FHA: 3.36 | FHA: 3.47 | FHA: Yes |
| IHA: 3.23 | IHA: 3.36 | IHA: 3.50 | IHA: Yes |
| NHA: 3.39 | NHA: 3.36 | NHA: 3.54 | NHA: Yes |
| VCHA: 3.03 | VCHA: 3.36 | VCHA: 3.52 | VCHA: Yes |
| VIHA: 3.13 | VIHA: 3.36 | VIHA: 3.55 | VIHA: Yes |

In 2020/21 all 5 health authorities were funded to meet the target of 3.36 HPRD, on average, and Quarter 3 HPRD results show all 5 health authorities are on track to meet or exceed this target, across their long-term care facilitates (based on forecast of total direct care hours to be delivered and forecast actual resident days).

[5] Data Source: Health Sector Compensation Information System (HSCIS), Health Employers Association of B.C.; measure is based on calendar year
[6] Data Source: Canadian Institute of Health Information, Health Sector Information, Analysis and Reporting Division, Ministry of Health
[7] Data Source: Provincial Infection Control Network of BC (PICNet)
[8] Data Source: Ministry of Health

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 24, 2021: Martin Wright, Health Sector Information, Analysis and Reporting Division
March 17, 2021: Antje Helmuth, Strategy Management Office, Deputy Minister's Office
March 17, 2021: Kerri Harrison, obo Philip Twyford, ADM, Finance and Corporate Services Division
March 18, 2021: Holly Moulton, Executive Operations, Deputy Minister's Office

# LEGISLATIVE SESSION - FACT SHEET

# 2021/22 Ministry of Health and Health Authority Planning Overview

## TOPIC

The Ministry of Health undertakes planning and reporting activities to establish clear direction and objectives for the health system, and to ensure alignment with government priorities. These activities guide the Ministry and health authorities in making decisions to improve service delivery, achieve optimal health outcomes, and use resources in a way that promotes efficiency and accountability.

## CURRENT SITUATION

See below key facts for a current update on each planning activity.

## KEY FACTS

- The **Minister's Mandate Letter** sets out the specific objectives and expectations for health service delivery to meet the population's health needs. A new letter was issued to the Minister on November 26, 2020.
- The **Ministry Service Plan and Annual Service Plan Report** ensure transparency and accountability to the public, as required under the *Budget Transparency and Accountability Act.*
    - The **service plan** identifies and communicates to the public and other stakeholders the purpose of the Ministry, key priorities, and the results it expects to achieve with the use of its financial resources. The *2021/22 Ministry of Health Service Plan* was published in April 2021, in conjunction with the budget.
    - The **annual service plan report** details the strategies and initiatives undertaken by the Ministry of Health toward achievement of the objectives set out in the previous year's service plan. The *2019/20 Ministry of Health Annual Service Plan Report* was tabled alongside public accounts and published on August 31, 2020.
- The **Health Authority Mandate Letters** articulate high-level direction for the fiscal year that forms the basis for priority setting within each health authority. The Health Authority Mandate Letters are issued annually, and finalized in spring. All five regional health authorities receive the same letter. A separate letter is issued to the Provincial Health Services Authority, recognizing their unique mandate.
    - The 2020/21 health authority mandate letters were sent to the health authorities for board member signature on February 19, 2020, prior to posting on their websites. The 2021/22 mandate letters are currently in development.
- **Health Authority Planning Documents** outline the roles, priorities, accountabilities, and deliverables of the health authorities. While not required under statute, health authority service plans and annual reports are requested by central government in alignment with requirements for Crown Agencies.
    - **Health Authority Service Plans** ensure transparency and accountability to the public by outlining goals, objectives and strategies. These plans are published annually and are public documents. 2020/21 Service Plans were developed by all health authorities and are now being posted to health authority websites.
    - **Health Authority Annual Service Plan Reports** compare health authority performance results with the targets outlined in the previous year service plan for a given fiscal year. These reports are published annually and are public documents. 2018/19 Annual Service Plan Reports were developed by all health authorities and have been posted to health authority websites. 2019/20 Annual Service Plan Reports for all health authorities are currently in development.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

May 6, 2021: Antje Helmuth, Strategy Management Office, Deputy Minister's Office

May 6, 2021: Holly Moulton, Executive Operations, Deputy Minister's Office

# LEGISLATIVE SESSION - FACT SHEET

# 2021/22 – 2023/24 Ministry of Health Service Plan Overview

## TOPIC

The *Ministry of Health 2021/22 – 2023/24 Service Plan* makes public the Ministry of Health's goals, objectives, and performance targets for the period, and also includes the Ministry's financial information as required under the *Budget Transparency and Accountability Act*.

## CURRENT SITUATION

The *2021/22 Ministry of Health Service Plan* was released publicly on Budget Day, April 20, 2021.

## KEY FACTS

- The service plan is intended to provide the public a high-level overview of the Ministry's strategic direction, key priorities, and the results it expects to achieve with the use of its financial resources.
- The 2021/22 Service Plan reflects government's strategic direction, and the Ministry's top priorities as outlined in the Minister's Mandate Letter of November 26, 2020. Specifically, the plan emphasizes:
    - cross health sector change initiatives in primary care, seniors, mental health and wait times;
    - improved health services for all including Indigenous populations; and
    - operational enablers, such as IMIT, health human resources and budgets, that deliver an innovative and sustainable public health care system.
- The goals remain unchanged from the previous plan. The 2021/22 Service Plan goals are:
    1. Ensure a focus on service delivery areas requiring strategic repositioning;
    2. Support the health and well-being of British Columbians through the delivery of high-quality health services; and
    3. Deliver an innovative and sustainable public health care system.

**Key changes for 2021/22:**

- Content has been added regarding B.C.'s response to the COVID-19 pandemic, including B.C.'s vaccination plan and rollout that is being implemented through Immunize BC.
- Under Objective 1.4 "Timely access to appropriate surgical procedures" key strategies have been replaced with standardized wording on B.C.'s Surgical Renewal Strategy following the temporary decision to postpone all non-urgent scheduled surgeries on March 16, 2020. To better demonstrate the emphasis on the Surgical Renewal Strategy as a priority:
    - **Performance Measure 1.4:** Total Operating Room Hours has **replaced** Surgeries in targeted priority areas completed.
- The *In Plain Sight* Report is identified as a blueprint for action to better express the Ministry's commitment to Indigenous Health and Reconciliation.
- **The nine performance measures are stated below exactly as presented in the 2021/22 – 2023/24 Ministry of Health Service Plan:**

| Performance Measure | Baseline | 2020/21 Forecast | 2021/22 Target | 2022/23 Target | 2023/24 Target |
|---|---|---|---|---|---|
| 1.1 Number of Primary Care Networks operating or in implementation | 0 (2016/17) | 53 | 65 | 85 | 85 |
| 1.2a Average direct care hours per resident day across all health authorities | 3.11 (2016/17) | 3.36 | 3.36 | 3.36 | 3.36 |
| 1.2b Potentially inappropriate use of antipsychotics in long-term care | 25.4% (2017/18) | 25% | 19% | 18% | 18% |

# LEGISLATIVE SESSION - FACT SHEET

| Performance Measure | Baseline | 2020/21 Forecast | 2021/22 Target | 2022/23 Target | 2023/24 Target |
|---|---|---|---|---|---|
| 1.2c Number of people with a chronic disease admitted to hospital per 100,000 people aged 75 years and older | 3,360 (2016/17) | 2,858 | 2,800 | 2,750 | ,700 |
| 1.3 Percent of people admitted for mental illness and substance use who are readmitted within 30 days | 14.7% (2016/17) | 15.4% | 14.0% | 13.9% | 13.8% |
| 1.4 Total Operating Room Hours | 545,419 (2016/17) | 569,700 | 666,500 | 676,500 | 682,700 |
| 2.1 Percent of communities that have completed healthy living strategic plans | 62% (2017/18) | 74% | 76% | 78% | 80% |
| 2.2 Rate of new *C. difficile* cases associated with a reporting facility per 10,000 inpatient days | 3.8 (2017/18) | 3.2 | 3.0 | 2.9 | 2.9 |
| 3.1 Nursing and allied professionals overtime hours as a percent of productive hours | 3.8% (2016) | 3.8% | 3.8% | 3.8% | 3.8% |

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

April 27, 2021: Kerri Harrison, Finance and Corporate Services
April 28, 2021: Antje Helmuth, Strategy Management Office, Deputy Minister's Office
April 28, 2021: Martin Wright, Health Sector Information, Analysis & Reporting Division
April 29, 2021: Holly Moulton, Executive Operations, Deputy Minister's Office

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# LEGISLATIVE SESSION - FACT SHEET

# 2021/22 to 2023/24 Ministry of Health Capital Budget

## TOPIC

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

## CURRENT SITUATION

- Capital funding for health authority capital projects comes from several sources.
- The Ministry provides health authorities 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 is available for major Public Private Partnerships (P3).
- The Ministry 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.
- See Financial Implications section for further information.

## KEY FACTS

- Health authorities obtain additional capital funding from own-source revenues, Regional Hospital Districts, Foundations, and Auxiliaries.
- Most new residential care or assisted living facilities are currently owned and financed by private for-profit and not-for-profit partners, with only a small number funded with Ministry capital. Additional funding has been added to the Ministry's 10-year Capital Plan for renewal and expansion of health authority-owned long-term care facilities.

RCG

The current 3-year budget and fiscal plan includes funding for:

- 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 (EHR) 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; and,
- Renewal and expansion of long-term care facilities, and hospital redevelopment and replacement projects.

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 21 health projects included in the $50 million table that will be released as part of the Financial and Economic Review, reflecting costs to March 31, 2021. As capital projects span multiple fiscal years, not all of the funding for these projects is included in the current 3-year budget and fiscal plan period.

Public Private Partnerships (P3)

Capital funding is being provided for two P3 projects: the Royal Inland Hospital – Patient Care Tower and Penticton Regional Hospital – Patient Care Tower projects, currently under construction.

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

Under the current 3-year budget and fiscal plan, the Ministry's capital budget for health authorities will be:

| Estimates Budget $ Millions - absolute (rounded) | 2020/21 | 2021/22 | 2022/23 | 2023/24 | Total 2021/22 to 2023/24 |
|---|---|---|---|---|---|
| Government Financial Information | | | | | |

Under the current 3-year budget and fiscal plan, the Ministry's capital budget for RCG only for health authorities will be:

| Restricted Capital Grants Estimates Budget $ Millions - absolute (rounded) | 2020/21 | 2021/22 | 2022/23 | 2023/24 | Total 2021/22 - 2023/24 |
|---|---|---|---|---|---|
| Government Financial Information | | | | | |

Sources:

- MOH Capital – 2020/21 – amounts as per Q3 19/20 capital submission to Ministry of Finance.
- MOH Capital – 2021/22 to 2023/24 – amounts per Q3 20/21 capital submission to Ministry of Finance.
- MOH operating amounts - as provided by Regional Grants & Decision Support.

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**Approved:**

June 2, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# 2021/22 Estimates

## TOPIC

The Ministry of Health's 2021/22–2023/24 Estimates were tabled on Budget Day, April 20, 2021.

## CURRENT SITUATION

The Ministry of Health will continue to support the response to the health-care requirements of COVID-19.
Government Financial Information

## KEY FACTS

This is the Ministry's 2021/22 – 2023/24 Estimates for Operating, Consolidated Revenue Fund (CRF) Capital and Restricted Capital Grants:

| | Restated 20/21 | 21/22 | % Increase Over Prior Year | 22/23 | % Increase Over Prior Year | 23/24 | % Increase Over Prior Year | Total 3 Year % Increase |
|---|---|---|---|---|---|---|---|---|
| Regional Services | 15,232,619 | 16,535,993 | 8.6% | 16,981,294 | 2.7% | 17,502,761 | 3.1% | 14.9% |
| Medical Services Plan | 5,242,763 | 5,550,427 | 5.9% | 5,838,225 | 5.2% | 6,043,225 | 3.5% | 15.3% |
| PharmaCare | 1,411,098 | 1,470,454 | 4.2% | 1,514,147 | 3.0% | 1,539,147 | 1.7% | 9.1% |
| Health Benefits Operations | 48,147 | 49,158 | 2.1% | 49,158 | 0.0% | 50,190 | 2.1% | 4.2% |
| | 21,934,627 | 23,606,032 | 7.6% | 24,382,824 | 3.3% | 25,135,323 | 3.1% | 14.6% |
| Minister's Office | 801 | 1,032 | 28.8% | 1,049 | 1.6% | 1,065 | 1.5% | 33.0% |
| Stewardship & Corporate Services | 254,207 | 265,884 | 4.6% | 265,884 | 0.0% | 277,229 | 4.3% | 9.1% |
| | 255,008 | 266,916 | 4.7% | 266,933 | 0.0% | 278,294 | 4.3% | 9.1% |
| | **22,189,635** | **23,872,948** | **7.6%** | **24,649,757** | **3.3%** | **25,413,617** | **3.1%** | **14.5%** |

| | Restated 20/21 | 21/22 | % Increase Over Prior Year | 22/23 | % Increase Over Prior Year | 23/24 | % Increase Over Prior Year | Total 3 Year % Increase |
|---|---|---|---|---|---|---|---|---|
| **Ministry CRF Capital** | **579** | **242** | **(58.2)%** | **30** | **(87.6)%** | **30** | **0.0%** | **(94.8)%** |
| **Restricted Capital Grants** | **1,007,505** | **1,406,522** | **39.6%** | **1,715,350** | **22.0%** | **2,148,059** | **25.2%** | **113.2%** |

## FINANCIAL IMPLICATIONS

The following budget adjustments were made to the prior year's Estimates.

- The Ministry Operating budget has increased due to the following:

| CRF Budget (in $000) | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|
| Budget 2020 - February 2020 | Government Financial Information | | |
| Sustainable Services Negotiating Mandate | | | |
| Community Social Services Recruitment and Retention | | | |
| Mental Health and Addictions (MHA) | | | |
| Cancer Services Caseload Pressures | | | |
| Diagnostic Imaging Strategy | | | |
| Surgical Strategy | | | |
| First Nations Cultural Safety and Humility | | | |
| Health Career Access Program (HCAP) | | | |

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Withheld pursuant to/removed as

Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

# Abbotsford Regional Hospital and Cancer Centre
# Emergency Department Expansion

## ISSUE

Status of the Emergency Department (ED) Expansion at Abbotsford Regional Hospital and Cancer Centre (ARHCC).

## CURRENT SITUATION

Construction is currently underway. The new ED triage was operational in January 2021. Substantial completion of the full project is scheduled for May 2021 and final occupancy in July 2021.

## KEY FACTS

Scope

The ED Expansion project (the Project) scope includes a 669 $m^2$ (7,200 sq. feet) ED expansion (single-storey build out to the west of the existing ED in the space currently utilized for ambulance bays), relocation of the ambulance bays next to the new build out, and renovations within the existing ED footprint to:

- Provide for an appropriately sized and designed ED to address congestion issues;
- Accommodate a Mental Health & Substance Use (MHSU) zone adjacent to but secured from the rest of the ED;
- Renovations to the existing Adolescent Day Treatment Program (ADTP) and Psychiatric Clinical Decision Unit (PCDU) space. The ADTP will be moved into offsite leased space and the PCDU will be moved to the renovated ADTP space;
- New trauma bays and 12 new patient exam rooms;
- Enhancement to the emergency registration function to include an element of triage;
- Renovations to the triage area;
- Dedicated stretcher bays;
- Creation of a nursing substation to manage Emergency Health Services/Ambulance offloads; and,
- Relocation of the ambulance bays to be next to the new ED.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Fraser Health Authority Internal Funding | 15.00 | 92% |
| Fraser Valley Health Care Foundation | 1.25 | 8% |
| **Total Project Cost** | **$16.25** | **100%** |

Schedule

| Milestone | Date |
|---|---|
| Government Approval of Project | March 2017 |
| *Announcement of Capital Funding for Project* | *April 3, 2017* |
| Request for Proposals (RFP) Issuance | February 2018 |
| Tender & Award | September 2019 |
| *Announcement of Construction Start* | *September 13 201* |
| ARHCC Emergency Department Expansion - Substantial Completion | May 2021 |
| **Open to Patients** | **July 2021** |

# LEGISLATIVE SESSION - FACT SHEET

Background

- Built as a Public Private Partnership (P3) in 2008, ARHCC contains 62,438 $m^2$ of floor space. However, since being built, there has been a significant increase in the number of ED visits that the existing ED space cannot appropriately accommodate, resulting in congestion and inefficient flow for trauma, cardiac, acute, and MHSU care.
- The 5-level ARHCC provides MRI services, general surgery and all inpatient and outpatient surgical services including vascular procedures, nuclear medicine, a full renal dialysis program, specialized obstetrics and maternity care, pediatric services, and special adult medical services.
- Government approved the ARHCC ED Expansion project in March 2017.
- On April 3, 2017, government announced a $15 million boost from the province to expand the ARHCC ED and add a dedicated area for MHSU care.
- Work on a functional program completed in February 2018.

## FINANCIAL IMPLICATIONS

The capital budget of the approved Project is funded with Restricted Global Operating funds and donations from the Fraser Valley Health Care Foundation.

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**Approved:**
March 4, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Administration and Support (10% Target)

### TOPIC

The Ministry of Health expects health authorities (HAs) to keep administration and support expenditures to 10% (or less) of total expenditures.

### CURRENT SITUATION

Northern Health Authority (NHA) is currently the only HA materially above the target of administrative and support expenses approximately equal to, or less than, 10% of total expenditures, at 12.40%.

### KEY FACTS

Since 2010/11 the Ministry has informed HAs in preliminary funding letters that all HAs will continue to achieve efficiency savings in administration and support program areas to attempt to keep these costs approximately equal to, or less than, 10% of total expenditures.

### FINANCIAL IMPLICATIONS

- HA administration and support expenditures as a percentage of total expenditures for the past 7 fiscal years are presented below:

| Health Authority | 2015/16 Actuals (Post Audit) | 2016/17 Actuals (Post Audit) | 2017/18 Actuals (Post Audit) | 2018/19 Actuals (Post Audit) | 2019/20 Actuals (Post Audit) |
|---|---|---|---|---|---|
| Fraser | 9.00% | 9.00% | 8.90% | 9.00% | 9.20% |
| Interior | 9.70% | 9.80% | 9.70% | 9.90% | 9.60% |
| Northern | 13.40% | 13.00% | 13.60% | 12.70% | 12.40% |
| Provincial Health Services | 9.40% | 9.40% | 9.80% | 10.30% | 10.70% |
| Vancouver Island | 10.50% | 10.30% | 10.00% | 9.60% | 9.40% |
| Vancouver Coastal | 10.10% | 10.40% | 10.30% | 10.90% | 10.80% |

Footnote:

1. Denominational affiliates are included above, including Providence Health Care with Vancouver Coastal Health Authority.
2. From 2015/16 to 2019/20, period 13 is used to calculate Vancouver Coastal Health Authority's percentages given year end adjustment anomalies.

- NHA has historically had higher than 10% administration expenses due to the high cost of energy and costs associated with delivering health services in a large geographical area.
- Starting April 1, 2018, BC Clinical and Support Services began reporting under the Provincial Health Services Authority which increased administration and support services expenditures for the HA.
- Vancouver Coastal Health Authority administration and support expenditures have increased primarily due to higher information system support expenses.
- Administration and support expenditures include finance services, human resources, system support, communications, emergency preparedness, material management, volunteer services, staff transport, interpretation or translation services, registration, health records and strategic health development and performance management.
- HA administrative expense information for 2020/21 is not yet available as the health authorities are involved in their year-end external audit processes; updated information will be available post-audit when the BC Public Accounts are released.

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**Approved:**
April 27, 2021 –Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Balanced Budget Financial Target

### TOPIC

It is Ministry of Health policy that health authorities (HAs) operate within balanced budgets to be consistent with the Ministry's requirement to adhere to the *Budget Transparency and Ministerial Accountability Act*.

### CURRENT SITUATION

In 2019/20, all HAs reported a combined surplus of $14.83 million (see Table 3).

### KEY FACTS

- In 2017/18, all HAs, other than the denominational affiliate Providence Health Care, reported surpluses and collectively HAs reported a combined surplus of $18.01 million (see Table 1).

Government Financial Information

### FINANCIAL IMPLICATIONS

- Table 1 shows 2017/18 actual HA revenue and expenses, excluding their denominational affiliates (other than Providence Health Care).

| Table 1<br>Health Authorities | 2017/18 Revenues ($Millions) | 2017/18 Expenses ($Millions) | 2017/18 Surplus/(Deficit) ($Millions) | Surplus/(Deficit) as of % of Total Revenue |
|---|---|---|---|---|
| Fraser Health Authority | 3,618.31 | 3,617.91 | 0.40 | 0.01% |
| Interior Health Authority | 2,209.66 | 2,203.47 | 6.19 | 0.28% |
| Northern Health Authority | 843.00 | 839.64 | 3.36 | 0.40% |
| Providence Health Care | 927.05 | 931.77 | (4.72) | (0.51%) |
| Provincial Health Services Authority | 3,026.37 | 3,025.67 | 0.70 | 0.02% |
| Vancouver Coastal Health Authority | 3,518.94 | 3,513.02 | 5.91 | 0.17% |
| Vancouver Island Health Authority | 2,425.90 | 2,419.73 | 6.17 | 0.25% |
| **Total** | 16,569.22 | 16,551.21 | 18.01 | 0.11% |

- Table 2 shows 2018/19 actual HA revenue and expenses, excluding their denominational affiliates (other than Providence Health Care).

| Table 2<br>Health Authorities | 2018/19 Revenues ($Millions) | 2018/19 Expenses ($Millions) | 2018/19 Surplus/(Deficit) ($Millions) | Surplus/(Deficit) as of % of Total Revenue |
|---|---|---|---|---|
| Fraser Health Authority | 3,796.89 | 3,814.99 | (18.10) | (0.48%) |
| Interior Health Authority | 2,331.34 | 2,355.98 | (24.64) | (1.06%) |
| Northern Health Authority | 892.65 | 896.68 | (4.03) | (0.45%) |
| Providence Health Care | 930.62 | 940.24 | (9.62) | (1.03%) |
| Provincial Health Services Authority | 3,637.19 | 3,645.44 | (8.26) | (0.23%) |
| Vancouver Coastal Health Authority | 3,710.04 | 3,730.99 | (20.95) | (0.56%) |
| Vancouver Island Health Authority | 2,549.70 | 2,563.49 | (13.79) | (0.54%) |
| **Total** | 17,848.42 | 17,947.81 | (99.38) | (0.56%) |

# LEGISLATIVE SESSION - FACT SHEET

- Table 3 shows 2019/20 actual HA revenue and expenses, excluding their denominational affiliates (other than Providence Health Care).

| Table 3<br>Health Authorities | 2019/20 Revenues ($Millions) | 2019/20 Expenses ($Millions) | 2019/20 Surplus/(Deficit) ($Millions) | Surplus/(Deficit) as of % of Total Revenue |
|---|---|---|---|---|
| Fraser Health Authority | 4,090.20 | 4,089.44 | 0.76 | 0.02% |
| Interior Health Authority | 2,527.95 | 2,527.58 | 0.36 | 0.01% |
| Northern Health Authority | 949.42 | 947.01 | 2.41 | 0.25% |
| Providence Health Care | 1,058.34 | 1,055.28 | 3.05 | 0.29% |
| Provincial Health Services Authority | 3,863.92 | 3,863.55 | 0.38 | 0.01% |
| Vancouver Coastal Health Authority | 4,022.80 | 4,015.42 | 7.38 | 0.18% |
| Vancouver Island Health Authority | 2,770.77 | 2,770.28 | 0.49 | 0.02% |
| **Total** | 19,283.39 | 19,268.56 | 14.83 | 0.08% |

**Approved:**
May 11, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Birth by Non-BC Residents

### TOPIC

- There is concern that non-resident (NR) births in BC are adversely affecting BC residents' access to care and the provincial health care system in general.
- Vancouver Coastal Health Authority (VCH) and Providence Health Care (PHC) have been identified as having hospitals with higher than normal NR birth rates, which is causing concern about their capacity to provide hospital care.

### CURRENT SITUATION

- The NR birth rate was approximately 2% of total births in BC in 2018/19, according to data from the Ministry of Health. This information was publicized by *The Vancouver Sun* on May 15, 2019. NR birth rate data for 2019/20 is not available.
- VCH invoiced NRs approximately $45 million for all NR services in 2017/18, with approximately 80% collected. Of this $45 million, VCH has invoiced NRs for approximately $6.2 million in maternity services at Richmond Hospital (RH) and has recovered approximately 80% of that amount. Similarly, in 2018/19 and 2019/20, VCH invoiced NRs $5.4 and $6.3 million in maternity services at RH, with a recovery rate of approximately 95% and 97%, respectively.
- VCH has reported an increase in NR births at RH from 22.1% in 2017/18 to 23.1% in 2018/19 to 24% in 2019/20. This accounts for the highest percentage of any hospital in Canada, according to data compiled by the *Canadian Institute for Health Information (CIHI).*
- The CIHI also lists PHC's St. Paul's and Mount Saint Joseph Hospitals as accounting for the second highest increase in NR births in Canada at 14.1%, with the remaining list of hospitals in the top 10 being in Ontario.
- Capacity to care for maternity patients at RH has been a point of concern. From April 2018 to August 2020, there were 22 maternity diversions from Richmond to other hospitals in different Health Authorities (HAs). During the same period, there were 16 diversions to RH from other HAs.
- The global travel restrictions brought about by the COVID-19 pandemic as well as increased scrutiny of passengers pre-boarding is expected to decrease the NR birth rate. This decrease is supported by preliminary data from VCH who is reporting a 56% decrease in the number of NR births at RH for Q3.

### KEY FACTS

- Under Canadian law, any baby born in Canada is automatically granted Canadian citizenship, regardless of the citizenship of the parents.
- There are situations where NRs use the Canadian health care system to deliver babies, referred to in the media as "birth tourism." Pregnant NR mothers come to Canada to give birth to gain Canadian citizenship for their baby.
- HAs do not refuse service based on an inability to pay. However, NRs are required to pay for any hospital services they receive, including paying a deposit for natal care.
- The Ministry's Eligibility, Compliance and Enforcement Unit (ECEU) conducts regular reviews of Medical Services Plan (MSP) recipients who cease to meet the definition of a resident under the Act. Security Concern

Security Concern

<u>Audit Activity and Legislative Authority</u>

- The Medical Services Commission has delegated to the ECEU, the investigative powers of the commission associated with Section 5(1)(f) of the *Medicare Protection Act* (MPA) and Section 5(4)(b) of the *Hospital Insurance Act* to ensure that hospital benefits are only paid for eligible MSP beneficiaries.
- Section 7.4(1)(b) and Section 30(1.1) of the MPA authorizes the cancellation of enrolment if the person ceased to be a resident and the recovery of those ineligible benefits.

- The ECEU is aware of private residences that provide room and board services to foreign pregnant women who come to BC to give birth. These residences are commonly referred to as "baby houses."
- These residences are used by two groups:
    - Individuals who are not enrolled in the BC MSP who come to BC to deliver a baby. These individuals self-report as NRs and pay for all medical and hospital charges out-of-pocket and are not investigated by the ECEU.
    - Individuals who are enrolled in MSP but cease to meet the definition of a resident under the MPA. All medical and hospital benefits are covered through MSP, even though they have lost eligibility for those benefits.
- Security Concern

- Of the cases ECEU investigated, VCH is generally the most prevalent location for NR births in BC. In 2020/21 to date, VCH had the highest number of investigations with 15 cases, followed by the Provincial Health Services Authority with 10 cases and Fraser Health with 6 cases.
- The ECEU assesses the eligibility of returning residents who were previously investigated and who re-apply for MSP to ensure their eligibility for re-enrolment. Security Concern
Security Concern

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## FINANCIAL IMPLICATIONS

- In fiscal 2020/21 to date, the costs relating to NR births investigated by the ECEU total $715,616, identified for recovery by HAs, Pharma Care, and MSP.
- HAs are responsible for collecting money owed to them for NR births, while the Ministry of Finance is responsible for the recovery of MSP and Pharmacare benefits.

| **Costs identified for recovery** | | | | | |
|---|---|---|---|---|---|
| **2018/19*** | | **2019/20** | | **2020/21 (Q3)** | |
| | **$471,764** | | **$1,069,390** | | **$715,616** |
| HA 79.6% | $375,733 | HA 84.1% | $899,321 | HA 84.1% | $636,474 |
| MSP 20.30% | $95,963 | MSP 15.8% | $169,013 | MSP 15.8% | $78,995 |
| PC 0.0% | $68 | PC 0.1% | $734 | PC 0.0% | $147 |

*The reduced costs identified for recovery in 2018/19 were due to a shift in focus to BC Services Card investigations.

**Approved:**
February 5, 2021 - François Comeau, Manager, Eligibility, Compliance and Enforcement Unit
February 9, 2021– Marie Thelisma, Audit and Investigations
February 21, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Burnaby Hospital Emergency Department Expansion

### TOPIC

Update on the Burnaby Hospital (BH) Emergency Department (ED) Mental Health and Substance Use (MHSU) and Community Health Services project (the Project).

### CURRENT SITUATION

The project completed under budget in January 2020, at a total capital cost of $10.65 million.

### KEY FACTS

The BH ED was originally built in 1952 at a time when the focus of emergency care was on medical/surgical care needs, and it did not have the appropriate types or quantities of care spaces to meet current and projected MHSU patient demand. This project renovated space to create a dedicated MHSU zone for the ED and consolidated various community health services that were inefficiently dispersed throughout the hospital.

Scope

The Project was designed to:

- Create a consolidated Community Health Services area on level 1;
- Relocate displaced services to a vacant and underutilized space on level 1;
- Create a 5-treatment space, 240 $m^2$ MHSU area adjacent to the existing ED on level 3 in the West Wing Building with a separate entrance, providing patients with privacy and comfort, a secure isolation room, and confidential assessment rooms; and,
- Relocate historic patient health records off-site.

The completed renovations include the following:

**Level 1**

- Constructed a new main entry vestibule and volunteer information booth;
- Decanted archived health record files offsite and constructed a new support services space to accommodate health records management and coding;
- Demolished existing corner of lab, refresh lab waiting area, and public washrooms; and,
- Constructed a new Community Health Services area.

**Level 3**

- Demolished a vacated patient registration area;
- Constructed a new dedicated MHSU care zone; and
- Constructed a new exterior canopy linking the existing ED entrance to a new MHSU care zone entrance.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Burnaby Hospital Foundation | 1.50 | 11% |
| Fraser Health Authority Internal Funding | 12.30 | 89% |
| **Total Project Cost** | **$13.80** | **100%** |

# LEGISLATIVE SESSION - FACT SHEET

Schedule

| Milestone | Date |
|---|---|
| Treasury Board Approval of Business Plan | November 2016 |
| *Announcement of Project Approval* | *April 6 2017* |
| Design/Planning | October 2018 |
| Construction Start | November 2018 |
| BH ED MHSU and Community Health Services - Substantial Completion | January 2020 |
| *New MHSU Zone Unveiled at BH* | *January 7 2020* |

Background

- BH opened in 1952 and has been constructed and reconstructed over many years in phases with additions, expansions, and renovations.
- BH is one of the largest community hospitals outside of the City of Vancouver, serving the City of Burnaby and the region of East Vancouver.
- The My Burnaby Hospital Community Consultation Committee collected community input on BH issues from May to October 2012. It publicly released its findings in a Citizen Report on November 29, 2012.
- The Citizen Report highlighted several issues including perceived lack of resources relative to other Fraser Health Authority (FHA) facilities, inadequate ED facilities, mismanagement of urgent safety requirements, allocation of operating room time and aging physical infrastructure. The report indicates that FHA is responsible for many of the issues and makes several comparisons to resources allotted to other FHA facilities.
- In a separate initiative, the Ministry of Health, in cooperation with FHA, undertook a focused look at issues at BH in October and November 2012. This resulted from concerns raised by BH physicians to the Minister of Health during a site visit in September 2012.
- Key informant interviews identified the most pressing problems at BH as the perception that BH was not given its fair share of resources; and the perceived lack of local autonomy to make routine decisions. Other major issues were the allocation of operating room time and dealing with an aging physical structure.
- In November 2016, Treasury Board approved the ED MHSU and Community Health Services Project.

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**Approved:**
March 4, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Burnaby Hospital Redevelopment

## TOPIC

Status update on the multi-phase Burnaby Hospital (BH) Redevelopment project.

## CURRENT SITUATION

- The Phase 1 Request for Proponents (RFP) was issued on June 22, 2020 to the following shortlisted proponents:
  - EllisDon with KRA/Diamond Schmidt/B+H (architects)
  - Ledcor with Stantec (architects)
  - Turner with Dialog (architects); withdrew from the RFP process in July 2020.
- Selection of a preferred proponent for Phase 1 is planned to occur in March 2021, with construction expected to start thereafter.
- Phase 2 detailed business planning is expected to commence in February 2021, and will confirm final Phase 2 scope, costs, and schedule.
- Following a fire at BH on November 15, 2020, the Cascade Building has been closed due to damage. The Building had accommodated inpatient and outpatient Mental Health and Substance Use (MHSU) Services, among other services. Immediate service continuity has been addressed by operational teams. The Cascade Building was planned for demolition at the end of Phase 1 once the new tower, renovations, and relocations were completed. Planning is underway for Cascade Building services for the medium and long term, including impacts to the Project.

## KEY FACTS

**Scope**

Phase 1A:

- Construction of a new 6-storey, 11,858 m², 78-bed, inpatient/outpatient tower (1A Tower) that will include an upgraded MHSU inpatient unit, relocated medical/surgical inpatient unit, outpatient clinics, and a new maternity ward.
- In June 2020, government approved an addition of an energy centre to the scope.

Phase 1B:

- Expansion and renovation of the 1978 Support Facilities Building (6,788 m² expansion and 4,386 m² renovation) will allow for 4 additional operating rooms, expanded emergency department, new pharmacy and medical device reprocessing department, additional parking (87 stalls), retail food services, and the creation of 18 new pre and post-op recovery spaces.
- Renovations to the 1978 Nursing Tower (284 m²) will facilitate the relocation of the medical/surgical inpatient unit and provide additional recovery space for the endoscopy suite.
- Demolition of the 1958 West Wing and 1973 Cascade building.

Project Board Scope Changes:

- On May 19, 2020, the Fraser Health Authority (FHA) Capital Project Board approved reallocating the MHSU Short-Stay Unit from Phase 2 to Phase 1.
- On August 18, 2020, FHA Capital Project Board approved pandemic impact changes, omission of emergency department Zone 3 renovations, deferring ED expansion to Phase 2, and relocation of diagnostic cardiology, virtual health reductions, and boiler plant replacement/demolition.

Phase 2

The Concept Plan proposed a second new inpatient tower and cancer centre.

Phase 1 Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Burnaby Hospital Foundation | 34.00 | 6% |
| Fraser Health Capital Funding | 30.40 | 5% |
| Provincial Funding | 512.82 | 89% |
| **Total Project Cost** | **$577.22** | **100%** |

# LEGISLATIVE SESSION - FACT SHEET



Schedule

| Milestone | Date |
|---|---|
| Treasury Board Approval (Phase 1 Business Plan/Phase 2 Concept Plan) | July 2019 |
| *Announcement of Burnaby Hospital Redevelopment Approval* | *September 3 201* |
| Phase 1 RFQ Issuance | December 2019 |
| Phase 1 RFP Issuance | June 2020 |
| Phase 1 Construction Start | August 2021 |
| Phase 1A New Energy Centre – Substantial Completion | February 2023 |
| Phase 1A New Inpatient/Outpatient Tower - Substantial Completion | October 2023 |
| Phase 1A New Inpatient/Outpatient Tower - Patient Occupancy | January 2024 |
| Phase 1B Nursing Tower and Support Facilities Bldg. Reno/Expansion and Demolition of West/North Wing and Cascade Buildings - Substantial Completion | March 2025 |

Government Financial Information

**Background**

- BH, one of the largest community hospitals outside of the City of Vancouver, opened in 1952 and has been constructed and reconstructed over the years with additions, expansions and renovations.
- BH provides acute and emergency care, general and internal medicine, general surgery, neonatal intensive care, palliative care, and an adult MHSU inpatient unit.
- In January 2017, FHA submitted a Concept Plan for a BH renewal project to the Ministry of Health. The Concept Plan focused on infrastructure renewal and minor expansion.
- In November 2017, government directed FHA to plan a larger redevelopment of the campus, with an enhanced Phase 1 Business Plan and a Concept Plan for the additional Phase 2. Treasury Board approved the Phase 1 Business Plan and the Phase 2 new Concept Plan in July 2019.
- On September 3, 2019, government announced approval of the BH Redevelopment Phase 1 Business Plan and the Phase 2 Concept Plan.
- The FHA Capital Project Board will oversee the redevelopment project through completion.

## FINANCIAL IMPLICATIONS

The final cost for BH Redevelopment Phase 2 will be determined in business planning, but the cost for the combined Phase 1 and Phase 2 is expected to be more than $1.3 billion.

**Approved:**
March 4, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Capital Funding for Long-Term Care Renewal and Expansion

### TOPIC

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

### CURRENT SITUATION

- Health authorities are working on detailed business plans for specific LTC projects to be funded from the LTC renewal and expansion capital funding envelope.
- When specific project business plans are completed, the Ministry of Health will seek Treasury Board approval of the business plans.
- The Ministry has established an advisory committee consisting of representatives from health authorities, the Ministry and Infrastructure BC to advise on standards and ways to expedite project planning and delivery.
- The lessons learned from the COVID-19 experience will be incorporated into the business plans.
- Opportunities to partner with non-profit organizations, municipalities, and regional hospital districts are being explored.

### KEY FACTS

- Much of the existing health authority-owned stock of LTC beds is old, physically deteriorated and/or functionally obsolete. There is need to invest in renewal or replacement of these facilities.
- As shown in the table below, the average age of heauth authority-owned long-term care facilities is 36 years with a aggregate Facility Condition Index (FCI) of 0.50. FCI is the ratio of the cost to correct identified deficiencies or deferred maintenance to the total cost of replacement of all current systems in the facility. The lower the FCI, the better the facility's condition and the lower the need for renovations or renewal funding relative to the facility's value (e.g. a FCI of 0.10 signifies a 10% deficiency, which is generally considered low, and a FCI of 0.70 means that a building needs extensive repairs or replacement).

**Health Authority-Owned Long-Term Care Facilities - as at May 14, 2021**

Advice/Recommentations; Government Financial Information

### FINANCIAL IMPLICATIONS

Advice/Recommentations; Government Financial Information

- In the Budget and Fiscal Plan for 2021/22 to 2023/24 government noted it is investing in renewal and expansion of health authority-owned long-term care facilities. Over 20 projects across the Province are in planning and expected to result in the replacement of approximately 2,850 beds and the creation of over 1,500 net new beds.
- 25 projects are currently in planning by health authorities (see Table). The scope, budget, schedule and procurement details of individual projects will be announced after the project business plans are approved by Government.
- When all projects are completed, the projects are expected to result in replacement of 2,850 beds (of which, 1,422 are currently in double- or multi-bedded rooms) and 2,158 net new beds. See the attachment for summary information about each project.

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Withheld pursuant to/removed as

Advice/Recommentations ; Government Financial Information

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Advice/Recommentations ; Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

## Cariboo Memorial Hospital Redevelopment

### TOPIC

Update on the status of the Cariboo Memorial Hospital (CMH) Redevelopment project (the Project).

### CURRENT SITUATION

The Project is in procurement. In October 2020, Project Board approved the issuance of the Design Early Works Agreement (DEWA) Request for Proposal (RFP) to the three shortlisted proponents and to post the draft Design Build Agreement (DBA) RFP in the data room for the Proponents' review and comment. The submission time for proposals closed January 13, 2021, and proponent team interviews are scheduled for February.

### KEY FACTS

Scope:

- The Project will be delivered in 2 phases:
    - Phase 1: Expansion through a new, approximately 9,500 $m^2$ (102,000 sq. feet) 3-storey (plus basement) addition, including: a new emergency department, pharmacy, medical/surgical inpatient units, a maternity and women's health unit, as well as infrastructure to support a future rooftop helipad.
    - Phase 2: Renovation of approximately 2,600 $m^2$ (28,000 sq. feet) of the existing facility to provide expanded ambulatory care, an adult psychiatric inpatient unit, UBC Faculty of Medicine education space, and an expanded main entry with interfaith sacred space.
- This phased approach requires the expansion to be completed before renovations begin.
- The Business Plan scope includes: 53 inpatient beds (an increase of 25 over current) with 41 (77 %) of the beds being single occupancy.

Budget

| Funding Sources | Project Cost ($ millions) | % of Total Project Cost |
|---|---|---|
| Ministry of Health Restricted Capital Grants (RCG) | 130.65 | 60% |
| Cariboo Chilcotin Regional Hospital District | 87.10 | 40% |
| **Total Project Cost** | **$217.75** | **100%** |

Schedule

| Milestone | Date |
|---|---|
| Concept Plan Approval | February 2018 |
| Business Plan Approval | June 2019 |
| *Announcement* | *July 2019* |
| DB RFQ Issued | December 2019 |
| Progressive DB RFQ Issued | April 2020 |
| RFP Issue | October 2020 |
| Construction Start | January 2022 |
| Substantial Completion | April 2024 |
| **Open for Patients** | June **2024** |

Background

- The CMH is a community hospital built in 1963 with an addition and renovations in mid-1970 for physiotherapy and medical records space, and a major building expansion in 1995.
- The CMH is 5 storeys, approximately 15,000 $m^2$ (161,000 $ft^2$) in size, and its Facility Condition Index is 0.49, based on a 2019 assessment.
- The hospital operates 28 inpatient beds and offers: emergency services, laboratory and diagnostic imaging services, obstetric care, outpatient care, and low complexity general surgery.

# LEGISLATIVE SESSION - FACT SHEET

- In 2011 the Interior Health Authority (IHA) completed a site master planning exercise to develop a conceptual future layout for the site. The site Master Plan looks at the existing location of the buildings and the proposed growth to outline a future phased expansion plan for a hospital site.
- The site Master Plan proposes several improvements, including a replacement inpatient unit, a two-level clinical expansion, and a small expansion to consolidate ambulatory care services and parking reconfiguration.
- In June 2015, IHA completed a Concept Plan for the redevelopment of CMH, and then submitted it to the Ministry of Health (the Ministry) in July 2015, seeking approval to proceed to a full Business Plan for the Project, however capital funding was not available at the time.
- As part of Budget 2017, the Ministry of Finance (MoF) added notional capital funding for the redevelopment of CMH to the Ministry's 10-year Capital Plan and requested the submission of an updated Concept Plan by November 2017.
- In October 2017, IHA submitted the revised CMH Redevelopment Concept Plan to the Ministry.
- The CMH Concept Plan identified a lack of space in several areas, resulting in various deficiencies which include inadequate infection controls, insufficient barrier-free space, lack of privacy, inefficient configuration of space and programs, and risks to both patient and staff safety. The following areas were identified as requiring urgent need for renewal and space expansion: inpatient unit, obstetrics unit, emergency services, ambulatory care, pharmacy services, and UBC medical school space.

## FINANCIAL IMPLICATIONS

- See Budget section for details regarding funding sources.
- The capital cost of the CMH Redevelopment is estimated at $217.7 million, Government Financial Information Governm based on a Class C cost estimate (accurate to +/- 15 %) provided as part of the Business Plan. The Ministry's
  10-Year Capital Plan includes $130.65 million in RCG funding for the CMH project.
- Of the total cost, approximately 80 % is allocated to the expansion component and 20 % to the renovation component.

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**Approved:**
March 4, 2021 - Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Costs of Health Care

### TOPIC

The Ministry of Health budget represents 41% of the total Provincial Consolidated Revenue Fund (CRF) budget in Budget 2021.

### CURRENT SITUATION

The Ministry will continue to support the response to the health-care requirements of COVID-19. Cabinet Confidences; Advice/Recommentations; Government Financial Information Government Financial

### KEY FACTS

Costs Drivers in Health Care

- Growing population – over the period 2021 to 2025, BC's population is projected to grow from 5,197,224 to 5,473,725 (5.3% increase).[1]
- 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 1,023,741 in 2021 to 1,180,431 by 2025 (an increase of 156,690 or 15.3%).[2] This also results in increased home care and residential care demands. The share of health expenditure spent on Canadians 65 and older was 44.2% in 2017. By comparison, the share spent on Canadians age 1 to 64 was 52.9% and was 2.9% for infants younger than age 1 in 2017.[32]
- 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).

Ongoing Management Strategies

- Continuing consultation with leaders in the industry.
- Four priority areas for service delivery action have been identified:
  1. Implementation of a primary care model that provides comprehensive and coordinated team-based care linked to specialized services;
  2. Improved health outcomes and reduced hospitalizations for seniors through effective community services;
  3. Improved health outcomes and reduced hospitalizations for those with mental health and substance use issues through effective community services; and,
  4. Timely access to appropriate surgical procedures.
- The Ministry's 3-Year Service Plan is at https://www.bcbudget.gov.bc.ca/2021/sp/pdf/ministry/hlth.pdf.

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[1] BC Stats – Population Projections Application website, last updated November 2020
https://www2.gov.bc.ca/gov/content/data/statistics/people-population-community/population/population-projections

[2] ibid

[3] National Health Expenditure Database, Canadian Institute for Health Information website National Health Expenditure Trends, 1975 to 2019

# LEGISLATIVE SESSION - FACT SHEET

Background

The Ministry of Health Estimates for Budget 2021 is proposed to have the following adjustments:

**Allocation of Operating Expenses - $000's**

| Core Business | 2020/21 Restated | 2021/22 Estimates | % Change | $ Change |
|---|---|---|---|---|
| **HEALTH PROGRAMS** | | | | |
| Regional Services | 15,232,619 | 16,535,993 | 8.6% | 1,303,374 |
| Medical Services Plan | 5,242,763 | 5,550,427 | 5.9% | 307,664 |
| PharmaCare | 1,411,098 | 1,470,454 | 4.2% | 59,356 |
| Health Benefit Operations | 48,147 | 49,158 | 2.1% | 1,011 |
| **Sub-Total** | 21,934,627 | 23,606,032 | 7.6% | 1,671,405 |
| **EXECUTIVE AND SUPPORT SERVICES** | | | | |
| Minister's Office | 801 | 1,032 | 28.8% | 231 |
| Stewardship and Corporate Services | 254,207 | 265,884 | 4.6% | 11,677 |
| **Sub-Total** | 255,008 | 266,916 | 4.7% | 11,908 |
| **Total – Ministry of Health** | **$22,189,635** | **$23,872,948** | **7.6%** | **$1,683,313** |

**Approved:**

May 7, 2021 - Peter Klotz, A/CFO, Finance and Corporate Services Division

June 3, 2021 - Philip Twyford, ADM, Finance and Corporate Services

# LEGISLATIVE SESSION - FACT SHEET

## Cowichan District Hospital Replacement

### TOPIC

Status of the Cowichan District Hospital (CDH) Replacement project (the Project) in Duncan.

### CURRENT SITUATION

Advice/Recommentations

- The Project will be delivered under a Community Benefits Agreement (CBA), the first provincial project to do so in the health sector.
- Request for Proposals (RFP) were issued for advisors to assist in developing a made-for-BC Alliance Contracting model, including solicitation and contract documents.
- The Request for Qualifications (RFQ) was released on December 18, 2020 and closes on February 25, 2021.
- The approval of up to three shortlisted respondents will occur in early April with the RFP (Phase I) being issued on April 19, 2021.
- The RFP (Phase I) will result in selection of two proponents to proceed to the Alliance Development Phase (RFP Phase II) which will ultimately result in selection of the preferred proponent.

### KEY FACTS

Scope

The approved Business Plan includes:

- Replacement of the existing CDH with a new hospital – estimated to be 46,000 $m^2$, an increase of approximately 30,000 $m^2$ – on a new site on Bell McKinnon Road;

Government Financial Information

- An increase in the number of inpatient beds (from 134 to 201) in modern, single-occupancy rooms with ensuite washrooms – replacing multi-patient rooms with shared washrooms;
- A new Emergency Department (ED), approximately three times larger than the current ED, which increases the treatment spaces to 36 (an increase of 19 spaces);
- 3 additional operating rooms and a fixed MRI machine, which replaces the mobile MRI that services CDH and West Coast General Hospital and 800 surface parking stalls.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Ministry of Health | Government Financial Information | |
| Cowichan Valley Regional Hospital District (CVRHD) | | |
| **Total Project Cost** | **$887.40** | **100** |

Schedule

| Milestone | Date |
|---|---|
| Concept Plan Approval | June 2018 |
| *Announcement of Concept Plan Approval* | July 2018 |
| Business Plan Approval | May 2020 |
| *Announcement of Business Plan Approval* | *TBD – Not Yet Announced* |
| Issue RFQ | December 2020 |
| Issue RFP | April 2021 |
| Construction Start | April 2022 |
| Construction Substantial Completion | April 2026 |
| **Open to Patients** | **October 2026** |

The Project schedule is tentative and will be further refined as the Project moves forward under the Alliance Contracting procurement model and the CBA.

Background

- CDH provides health services to the residents of Duncan, North Cowichan and surrounding areas.
- CDH was originally constructed in 1967, with additions and renovations in 1978 (ICU renovation); 1980 (behavioral inpatient); 1987 (radiology renovation); 1990 (ambulatory day surgery); 1995 (new ED) and 1998 (dialysis addition).
- VIHA identified the CDH replacement as its highest Priority Investment project for capital funding consideration.
- As part of Budget 2018, the Ministry of Finance (MoF) added Government notional capital funding for the replacement of CDH to the Ministry of Health's (the Ministry) Capital Plan (based on a high-level cost estimate of Government Financial
- In June 2018, Treasury Board approved VIHA's request to proceed with a detailed business plan for the CDH Replacement project.
- On July 6, 2018, an announcement was made by Premier John Horgan and Minister Adrian Dix in Duncan that the Concept Plan was approved and that the project would be moving to the business planning stage.
- As part of Budget 2019, MoF added an additional Government Financial to the Ministry's plan based on the Concept Plan cost estimate of Government

Government Financial Information

- On January 30, 2020, the final Business Plan was submitted to the Ministry.
- On May 13, 2020, Treasury Board approved the CDH project; an official government announcement has not been made.
- The project will be delivered under a CBA which includes the following highlights:
    - A targeted approach to maximizing apprenticeship opportunities on major public-infrastructure projects.
    - Focus on priority hiring and training of Indigenous peoples and women.
    - Co-ordinated access to existing training programs, while identifying and addressing skills gaps.
    - Priority hiring for qualified individuals who live within proximity of the projects.
    - Wage alignment to prevailing industry rates to promote good wages for all employees.

## FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Dawson Creek and District Hospital Redevelopment

## TOPIC

Update on the Dawson Creek and District Hospital (DCDH) Redevelopment project (the Project).

## CURRENT SITUATION

Advice/Recommentations

- On January 7, 2021, the Request for Qualification (RFQ) closed with four responses received.
- The RFQ evaluation has commenced and is expected to conclude February 25, 2021.
- A Report Back to the Chair of Treasury Board confirming the project cost, funding sources, and procurement model prior to issuing the Request for Proposal (RFP) is currently in process.

Government Financial Information

- The new hospital will be built on an unused 10-acre portion of land on the Northern Lights College (NLC) site to be purchased by Northern Health Authority (NHA).

Government Financial Information

## KEY FACTS

Scope

The approved Business Plan includes:

- A new hospital approximately 19,400 $m^2$ in size which would be an increase of approximately 4,000 $m^2$ over the existing DCDH. It will be constructed on a 10-acre greenfield site to be purchased from the NLC located kitty corner to the southeast of the current DCDH;
- 70 inpatient beds, for a net increase of 24 beds; and,
- Expanded emergency department, surgical/operating room space, and ambulatory care services.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Ministry of Health | 227.63 | 60% |
| Peace River RHD | 150.23 | 40% |
| **Total Project Cost** | **$377.86** | **100%** |

Government Financial Information

Schedule

| Milestone | Date |
|---|---|
| Concept Plan Approval | April 2018 |
| *Announcement of Concept Plan Approval* | *July 2018* |
| Business Plan Approval | April 2020 |
| *Announcement of Business Plan Approval* | *September 2020* |
| Issue RFQ | October 2020 |
| Issue RFP | February 2021 |
| Construction Start | November 2022 |
| Construction Substantial Completion | February 2026 |
| **Open for Patients** | **August 2026** |

# LEGISLATIVE SESSION - FACT SHEET

Background

- DCDH is a full-service community hospital that has 31 acute care beds and 15 regional adult psychiatric beds. DCDH was constructed in 1960 with an addition in 1996.
- Services include 24/7 emergency, ICU, medical and surgical inpatient care, and day surgery, as well as the specialty services of respiratory therapy, rehab therapy, diabetic education, primary care, general surgery, diagnostics including lab and medical imaging with CT, cancer care, and visiting specialists, including urology and dermatology, obstetrics and gynecology, and pediatrics.
- In fall 2015, NHA submitted a Concept Plan for the redevelopment of DCDH to the Ministry of Health (the Ministry) seeking approval and funding to develop a full Business Plan.
- As part of Budget 2018, Treasury Board added notional funding for the Project to the Ministry's 10-Year Capital Plan and requested NHA to submit an amendment to the 2015 Concept Plan, updating the Project cost and schedule.
- In March 2018, NHA submitted the Concept Plan amendment to the Ministry.
- In April 2018, Treasury Board approved the Concept Plan and NHA's request to proceed with a detailed Business Plan for the Project.
- The preferred option in the Concept Plan was to renovate and expand on the current site. After further examination during business planning, it was determined that a complete replacement is a better option.
- On December 19, 2019, NHA submitted the Business Plan to the Ministry.
- On April 29, 2020, Treasury Board approved the Business Plan subject to a review of the energy conservation bundles by the Climate Action Secretariat (CAS) and on July 9, 2020; the review was completed by CAS.
- On October 26, 2020, the RFQ was released and closed January 7, 2021.
- NLC offered to NHA an unused 10-acre portion on the north-west corner of their property, which could accommodate a replacement hospital, including all required inpatient beds, services, and parking. Compared to replacement on the existing site, this option is faster, less disruptive, allows for more optimal design, and is estimated to be less costly.
- The NLC Board of Governors and the Ministry of Advanced Education and Skills Training have approved the disposal of the site and the sale/transfer to NHA.

Advice/Recommentations; Intergovernmental Communications

## FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Eagle Ridge Hospital Emergency Department Expansion

## TOPIC

Update on the Eagle Ridge Hospital (ERH) Emergency Department (ED) Expansion project (the Project) in Port Moody.

## CURRENT SITUATION

- Construction for the relocation of Health Information Management, Cardiology, and Community Outpatient Services completed in May 2020.
- Construction for the ED expansion and renovations started in December 2019 and is expected to be completed in September 2021. The full project is scheduled to be completed in March 2022 and open to patients in April 2022.

## KEY FACTS

Scope

The Project is designed to alleviate the current and projected capacity pressures to 2030, as well as provide the necessary functional flexibility to adopt current innovations in clinical practice, medical technologies, and support. This will be accomplished with:

- Increased treatment spaces from 19 to 39;
- Increased ED space from 714 $m^2$ to 2,026 $m^2$;
- The addition of 4 isolation rooms, included in the 39 treatment spaces, to meet Canadian Standards Association (CSA) standards (there is currently 1, which does not meet CSA standards);
- 2 new trauma bays complete with articulating service booms;
- Separate soiled storage and clean areas;
- Expanded and zoned waiting areas for acute and sub-acute patients to provide efficient throughput; and,
- Various minor equipment.

Executive Steering Committee Scope Change:

- Modifications to the trauma and resuscitation bay due to COVID-19 lessons learned; and,
- Information management and information technology (IMIT) upgrades to add server capacity.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Eagle Ridge Hospital Foundation | 5.00 | 13% |
| Ministry Restricted Capital Grant (RCG) Funding | 9.88 | 26% |
| Fraser Health Authority Internal Funding | 22.62 | 60% |
| **Total Project Cost** | **$37.50** | **100%** |

# LEGISLATIVE SESSION - FACT SHEET

Schedule

| Milestone | Date |
|---|---|
| Government Approval of Business Plan | March 2017 |
| *Announcement of Business Plan Approval* | *March 29 2017* |
| *Announcement of Construction Start* | *January 18 2019* |
| Planning & Design* (Note: iterative over packages) | April 2019 |
| **Package 1: Cardiology & Clinical Outpatient Services** | |
| Tender & Award | January 2019 |
| Substantial Completion | May 2020 |
| Occupancy | June 2020 |
| **Package 2a: ED Expansion & Renovations** | |
| Tender & Award | January 2020 |
| Substantial Completion | September 2021 |
| Occupancy | September 2021 |
| **Package 2b: Renovations to Vacated Space (Future Rehab Space)** | |
| Substantial Completion | March 2022 |
| Occupancy | April 2022 |

*Note: Planning and design was an iterative and accommodated Package 2 construction delays for refresh of clinical planning, scope changes, and complex phasing.

Background

- ERH is a community hospital located in Port Moody providing primary and secondary services to Coquitlam, Port Coquitlam, Port Moody, and the villages of Anmore and Belcarra.
- The current ED opened in 1984 with an area of 714 $m^2$ and was designed to serve less than 20,000 visits annually.
- Based on current standards and projections, the ED is significantly undersized.
- In 2015/16, ED visits increased to over 51,000, and by 2030 annual visits are projected to be over 68,000 - an increase of 240% from the original design expectations.
- In 2013, a High-Level Master Plan (HLMP) was completed for ERH. This plan identified the ED expansion as a high priority due to population growth, non-compliance with infection control standards/measures and safety risks.
- In February 2017, FHA submitted the final Business Plan to the Ministry of Health.
- In March 2017, the ED Expansion Project was approved by Treasury Board.
- Start of construction was announced on January 18, 2019.

## FINANCIAL IMPLICATIONS

In March 2020, Treasury Board approved an increase to the total capital cost of the Project by $9.88 million in RCG funding for a revised total project cost from $27.62 million to $37.5 million.

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**Approved:**
March 4, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Extra-billing - Audits and Canada Health Transfer Penalties

### TOPIC

Several private health clinics and Medical Service Plan (MSP) enrolled physicians are privately charging patients for services under the Medicare Protection Act (MPA) and the Canada Health Act (CHA). This is referred to as "extra-billing" and is prohibited under the MPA and CHA.

### CURRENT SITUATION

- On September 10, 2020, the Honourable Mr. Justice Steeves delivered his reasons for judgement in the Cambie Surgeries Corporation v. British Columbia (Attorney General) trial. The decision ruled in the Province's favour on all counts; all sections of the MPA being challenged were upheld. Lawyers for Cambie Surgeries Corporation (Cambie) have applied to appeal the decision.
- Going forward, 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. In accordance with Health Canada (HC) requirements, the Billing Integrity Program (BIP) will be performing on-site audits for four private billing clinics in the fall and winter of 2020/21.

### KEY FACTS

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 2017, a new methodology was agreed upon between HC and BC to improve the accuracy of these reported extra-billings. In 2018, the federal Minister of Health wrote to Provincial/Territorial Health Ministers formalizing three new initiatives to improve compliance with the CHA: The Diagnostic Service Policy, The Reimbursement Policy and strengthened reporting.
- October 2018, enforceability of the Bill 92 provisions was challenged in Court in Cambie Surgeries Corporate v. British Columbia (Attorney General).
- November 23, 2018, the BC Supreme Court issued an injunction prohibiting the enforcement of the extra-billing provisions (s. 17, 18, and 45 of the MPA) until June 1, 2019 or further order of the Court.
- June 2019, the injunction ended.
- July 2019, Cambie brought an application for an injunction to prevent the Province from enforcing extra-billing provisions in relation to surgeries at private medical clinics.
- September 2019, there was an agreement regarding the extra-billing injunction application; the MSC cannot refund patients in relation to private surgeries, and then seek recovery of monies from the private clinics. The injunction also prevents the use of the offence provisions (including levying fines) contained in the MPA.
- October 2019, both parties entered a Consent Order until the Cambie trial decision is issued. The Consent Order provided certainty that the Ministry of Health (the Ministry) can audit these facilities, but cannot reimburse patients, seek recovery of extra-billing amounts, or enforce the offence provisions of the MPA.
- September 10, 2020, the Consent Order expired upon receipt of the decision from the BC Supreme Court.
- October 2020, following this decision from the Court, Cambie et al. submitted a new application for injunction seeking to continue to prohibit the Province from enforcing certain provisions of the MPA until such time that the appeal is heard.
- On December 8, 2020 the Court of Appeal issued a limited form of injunction which prohibits the Medical Services Commission (MSC) from issuing refunds to patients (section 21(2) and (3)), applying for injunctions against those who are extra billing (section 45.1) and levying fines (section 46(5.1) and (5.2)) for any private surgeries where a patient has been scheduled for a date beyond Ministry wait time benchmarks or where a surgery has not taken place by the date set according to such wait time benchmarks. This injunction is in effect until June 18, 2021 or further order of the Court.

# LEGISLATIVE SESSION - FACT SHEET

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.
- Audits assess whether beneficiaries were charged for or in relation to a benefit contrary to the Act and its regulations, and, if so, the amount of extra-billing, and whether MSP and beneficiaries were both charged.
- The MSC has approved six audit reports since October 2018, with the three most recent in May 2019. In July 2019, the MSC issued final audit reports to all six auditees, accompanied by a letter from the MSC Chair. No recovery is expected. Cambie is not included in this amount, as it was reported to the MSC in 2012.
- BIP has conducted three on-site audits in fiscal 2020/21. Detailed audit activity is available in the Extra-billing – Clinic Audits fact sheet.

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 Audits | Additional HC Assessment* | Total |
|---|---|---|---|---|
| 2018/19 | $200 | $13,949,779 | | $13,949,979 |
| 2017/18 | $1,229 | $16,752,272 | | $16,753,501 |
| 2016/17 | $7,533 | $16,169,726 | | $16,177,259 |
| 2015/16 | $1,980 | $15,861,818 | | $15,863,798 |
| 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 |
| 2009/10 | $33,179 | | | $33,179 |
| 2008/09 | $75,136 | | | $75,136 |

* based on specific findings in Cambie

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 MSP 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 Audit and Inspection Committee recommends audit referrals to the MSC for approval. MSC approved audits are delegated to the Ministry's Audit and Investigations Branch (AIB). AIB's BIP performs extra-billing audits and presents audit reports to the MSC for approval.

Release of Information

This information may be disclosed to the public.

## FINANCIAL IMPLICATIONS

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

| | |
|---|---|
| Total penalties assessed since March 2018 | $62,742,889 |
| Less: 50% reimbursement of deductions from March 2018 and March 2019 CHT Payment | ($16,019,539) |
| Net penalties assessed since March 2018 | $46,723,350 |

- BC Health Authorities have entered into $67.9 million multi-year contracts with private clinics to provide beneficiary services and increase access. A clear stipulation in agreements between private clinics and health authorities is a requirement that partner clinics do not engage in extra-billing of any kind.

**Approved:**

February 3, 2021 – Tamra McQuitty, Director, Billing Integrity Program
February 9, 2021– Marie Thelisma, Executive Director, Audit and Investigations Branch
February 21, 2021 – Philip Twyford, Assistant Deputy Minister, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## First Nations Health Authority

### TOPIC

In 2011, the First Nations Health Society, federal government, and provincial government finalized the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (the Framework Agreement). The Society has now evolved into the First Nations Health Authority (FNHA). The FNHA receives funding from the Ministry of Health through the Framework Agreement, as well an accompanying Medical Services Plan (MSP) Agreement which outlines funding commitments for health insured services for First Nations.

### CURRENT SITUATION

FNHA had a surplus of $1.63 million in its 2019/20 Audited Financial Statements.

### KEY FACTS

Framework Agreement

- In 2011, the FNHA, federal government, and provincial government finalized the Framework Agreement, which includes provisions for the transfer of the planning, design, management, and delivery of First Nations health programs from the federal government to a new FNHA.
- On October 1, 2013, the transition of programs and services designed for First Nations and managed by Health Canada were transferred to the FHNA.
- The Canada Funding Agreement provides funding to the FHNA to support the transfer of federal health programs and support the planning, design, management, delivery and funding of health programs by the FNHA.
- The total funding under the Canada Funding Agreement is $4.7 billion over 10 years (beginning July 2, 2013, and expiring March 31, 2023). As outlined in the Framework Agreement, the province has committed $100 million in funding up to 2019/20.

MSP Agreement

- Prior to the Framework Agreement, Health Canada provided MSP payments to the Ministry on behalf of BC First Nations as per a Memorandum of Understanding between the federal government and Province of BC. As of July 2, 2013, the FNHA assumed financial and administrative responsibility for First Nation clients whose MSP premiums were previously covered by the federal government.
- As part of an MSP Agreement, the FNHA agreed to provide 75% of annual financial contribution commitment directly to the Ministry of Finance and set aside 25% of annual financial contribution commitment to support MSP primary care related initiatives. These primary care initiatives do not include MSP funded services, but broader initiatives such as e-health to improve health delivery services to First Nations.
- A FNHA and Ministry Joint Project Board was established to identify priority projects to apply this funding. As part of the MSP Agreement, the FNHA funds the initial start-up costs and first year of the project's operations, then the Ministry commits to sustaining the project thereafter. The MSP Agreement was extended to March 2020 but although it has now expired, the commitment to maintain the funding continues.

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

Framework Agreement

- At the end of fiscal year 2019/20, the Ministry provided $100 million to the FNHA to support the Framework Agreement. The funding schedule up to 2019/20 is provided in the table below:

| Fiscal Year | Amount ($ millions) |
|---|---|
| 2006/07 to 2014/15 | $45.00 |
| 2015/16 | $11.00 |
| 2016/17 | $11.00 |
| 2017/18 | $11.00 |
| 2018/19 | $11.00 |
| 2019/20 | $11.00 |
| **Funds Provided from 2006/07 to 2019/20** | **$100.00** |
| **Total Commitment** | **$100.00** |

- Although the Ministry has provided the full amount of funding related to this commitment, in 2019/20 the Ministry provided a further lump sum of $22.0 million to further support the FNHA.

Other Funding

- To support Joint Project Board projects, the Ministry provided:
  - $5.51 million in 2016/17;
  - $7.88 million in 2017/18;
  - $10.27 million in 2018/19;
  - $13.17 million in 2019/20; and

Government Financial Information

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**Approved:**
May 6, 2021 –Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Fraser Health Authority

### TOPIC

- The Fraser Health Authority (FHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the FHA via the annual Regional Services funding allocation.

### CURRENT SITUATION

- FHA had a surplus of $0.764 million in its 2019/20 Audited Financial Statements excluding affiliates, creating a surplus of $0.325 million with Menno and St. Michael's included.

### KEY FACTS

- This Ministry's Regional Services funding represents the vast majority of the FHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).
- Working in co-operation with the FHA to provide health services within the FHA region are 2 denominational affiliates or hospital societies established per the *Hospital Act* (i.e., Menno Hospital and St. Michael's Centre). These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements.
- The Ministry does not provide operating funding directly to the denominational affiliates; the FHA is responsible for allocating operating funding to the denominational affiliates. The financial results of the FHA and the denominational affiliates are consolidated in the Government Reporting Entity.

### FINANCIAL IMPLICATIONS

- 2019/20 Audited Financial Statements of FHA (Excluding Menno and St. Michael's)
  - Total Revenues $4,090.202 million
  - Total Expenses $4,089.438 million
  - Surplus (Deficit)$ 0.764 million

2019/20 Breakdown of Total Revenues by Major Funding Source
Year Ended March 31, 2020
($ Millions)

| | Budget | 2020 | 2019 |
|---|---|---|---|
| **Revenues** | | | |
| Ministry of Health Contributions | 3,260.000 | 3,404.102 | 3,135.745 |
| Medical Services Plan | 181.300 | 200.809 | 194.401 |
| Recoveries from other health authorities and BC government reporting entities | 122.600 | 124.734 | 122.122 |
| Patients, clients and residents | 92.500 | 108.377 | 105.110 |
| Other contributions | 85.700 | 91.064 | 85.656 |
| Amortization of deferred capital contributions | 85.400 | 84.373 | 86.175 |
| Other | 36.019 | 71.449 | 62.595 |
| Interest income | 2.781 | 5.294 | 5.087 |
| | 3,866.300 | 4,090.202 | 3,796.891 |

Note: Amounts as per 2019/20 audited financial statements.

# LEGISLATIVE SESSION - FACT SHEET

- Regional Services Funding Allocation (to FHA from Ministry)
  - 2017/18 - $2.984 billion (per 2017/18 Final Funding Letter)
  - 2018/19 - $3.141 billion (per 2018/19 Final Funding Letter)
  - 2019/20 - $3.416 billion (per 2019/20 Final Funding Letter)

Government Financial Information

- Estimated Full-Time Equivalents (FTEs)
  - According to Health Sector Compensation Information System 2019 Quarter 4 data, the estimated number of FTEs – excluding Menno Hospital, St. Michael's and Other Contracted Agencies – is as follows:
    - Union – 17,734
    - Non-Union/Management – 1,888

Government Financial Information

- FHA Population
  - According to BC Stats, the FHA's population forecast and rate of growth is as follows:
    - 2020/21 - 1.967 million, 1.46% growth
    - 2021/22 - 1.998 million, 1.58% growth
    - 2022/23 –2.031 million, 1.65% growth
  - As of November 2020, approximately 16.3% of FHA's population is age 65 and over.

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**Approved:**
May 6, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# G.R. Baker Memorial Hospital ED/ICU Project

## TOPIC

Update on the G.R. Baker Memorial Hospital (GRBMH) Emergency Department (ED) and Intensive Care Unit (ICU) Project (the Project) in Quesnel.

## CURRENT SITUATION

- The main ED/ICU project was tendered in July 2020 and awarded in August 2020 to True Construction Ltd. from Kamloops.
- Construction commenced in September 2020 and is estimated to complete in March 2022. Excavation work for the foundation of the new ED/ICU has continued which includes the removal of old foundations, abandoned services, and other unforeseen objects.
- Work on footings and foundation is expected to begin in February/March 2021.
- An archeologist and representatives from local First Nations remain on site during the bulk excavation in case any further human remains are found. At this time no further archeological objects have been found.

## KEY FACTS

Scope

- The Project includes a 1,467 $m^2$, newly constructed extension adjacent to the main floor of GRBMH to co-locate the ED and ICU.
- The new ICU will include: 5 ICU examination/treatment rooms (2 capable of functioning as isolation rooms), 1 secure medication room, a secure nurse station/control centre with views to the ICU rooms, improvements to operational support spaces for staff, and a private family waiting room.
- The new ED will provide modern patient care that aligns with current design standards and provincial guidelines, including increased line-of-sight for patient and visitor traffic and psychiatric observation areas.
- The co-location of the ED and ICU will establish a safe and secure environment that improves infection control and effectively manages staff and patient workflows.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Ministry of Health | Cabinet Confidences; Government Financial Information | |
| Cariboo-Chilcotin RHD | | |
| **Total Project Cost** | **$27.00** | **100%** |

Schedule

| Milestone | Date |
|---|---|
| Business Plan Approval | March 2019 |
| *Announcement of Business Plan Approval* | *April 2019* |
| Issue RFP | June 2020 |
| Construction Start | September 2020 |
| Construction Substantial Completion | May 2022 |
| **Open for Patients** | **July 2022** |

# LEGISLATIVE SESSION - FACT SHEET

Background

- GRBMH is a 36-bed community hospital with 4 ICU beds and 5 crisis stabilization beds.
- The hospital was constructed in 1954 with additions in 1962 and 1972. In 1986 a large 3-storey building was added.

Advice/Recommentations

- In late April 2016, NHA laid out a proposal to Quesnel City Council for a project to expand the ED and ICU at GRBMH.
- In December 2018, NHA submitted a Business Plan for a proposed 1,467 $m^2$ newly constructed extension adjacent to the main floor of GRBMH to co-locate the ED and ICU at an estimated cost of $27 million.
- Cabinet Confidences; Government Financial Information

- As part of Budget 2017, the Ministry of Finance (MoF) added notional capital funding for the Project to the Ministry's Capital Plan; however, to date, funding for the proposed GRBMH replacement project has not been allocated.
- In March 2019, Treasury Board approved the Business Plan and confirmed provincial funding submission for the new ED/ICU project estimate of $27 million.
- In December 2019, an Early Works Contract was awarded to a local firm for site preparation and relocation of underground services. During excavation, human remains were found on two occasions (July 2019 and March 2020).
- Representatives from local First Nations (Lhtako Dene, Tsilhqot'in), the BC Heritage Branch, Ministry of Citizens' Services, and an archeologist from Stantec were involved since the beginning of planning in 2018. The remains were only partially disturbed and were replaced where they were found and recovered.
- Work on the Archaeological Impact Assessment (AIA) required for the early works phase was complete as of June 5th, 2020, and a final report submitted to the Archaeology Branch.
- In addition to the ED/ICU project, NHA has a $5 million kitchen renovation project underway which is estimated to complete in January 2021. The project was also awarded to True Construction Ltd.

## FINANCIAL IMPLICATIONS

Government Financial Information

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**Approved:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Authorities Bad Debt Write-Offs

### TOPIC

Regional health authorities write off unpaid medical bills by non-residents of Canada once it is established they cannot be collected. Health authorities work with individuals and their insurers to recover unpaid bills; however, in some cases, those costs are unrecoverable and have to be written off.

### CURRENT SITUATION

Health authorities wrote off $20.20 million in 2019/20 because of unpaid medical bills by non-residents of Canada – or less than 8/100ths of 1% of the $23.4 billion spent in the health system last year.

### KEY FACTS

- In BC's public health care system, no one will ever be denied essential medical care in emergency situations. A person's ability to pay is not a consideration in providing care.
- Before any services are provided to non-residents of Canada, patients are asked to complete a responsibility of payment form and payment is collected up-front whenever possible.
- The Ministry of Health, in collaboration with health authorities, establishes standardized rates for health authorities to charge non-residents of Canada for health services.
- Patients are informed of the costs prior to discharge and the accounts receivable department for each health authority works with the patient and their insurer, if they have one, to collect the monies owed.
- Health authorities have procedures in place to collect payment from non-residents of Canada who use our medical services to minimize bad debt.
- Accounts that are not collectible are referred to a collection agency.

### FINANCIAL IMPLICATIONS

- The following table shows that over the last 5 years, health authorities wrote off $61.26 million because of unpaid medical bills by non-residents of Canada as reported in the health authority audited financial statements.

| ($ millions) | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | Total |
|---|---|---|---|---|---|---|
| Fraser Health Authority | 3.20 | 4.24 | 4.40 | 6.08 | 12.61 | 30.53 |
| Interior Health Authority | 0.58 | 2.77 | 0.23 | 3.18 | 0.14 | 6.89 |
| Northern Health Authority | 0.11 | 0.12 | 0.16 | 0.32 | 0.25 | 0.96 |
| Provincial Health Services Authority[1] | 0.32 | 0.31 | 0.23 | 0.15 | 0.56 | 1.55 |
| Vancouver Coastal Health Authority[2] | 0.66 | 3.39 | 3.06 | 4.06 | 4.87 | 16.04 |
| Vancouver Island Health Authority | 0.66 | 0.92 | 1.19 | 0.75 | 1.77 | 5.29 |
| **Total** | **5.53** | **11.74** | **9.26** | **14.53** | **20.20** | **61.26** |

1. Includes BC Emergency Health Services (BCEHS)
2. Includes Providence Health Care and Uninsured Residents Write-offs

# LEGISLATIVE SESSION - FACT SHEET

- The following table shows that over the last 5 years, health authorities collected $516.69 million in revenue from non-residents of Canada as reported in the health authority audited financial statements.

| ($ millions) | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | Total |
|---|---|---|---|---|---|---|
| Fraser Health Authority | 17.26 | 21.35 | 23.40 | 25.19 | 30.38 | 117.59 |
| Interior Health Authority | 11.42 | 12.49 | 13.60 | 14.58 | 15.19 | 67.27 |
| Northern Health Authority | 1.21 | 1.56 | 1.97 | 2.04 | 2.38 | 9.16 |
| Provincial Health Services Authority[1] | 3.58 | 5.92 | 4.96 | 8.14 | 7.71 | 30.31 |
| Vancouver Coastal Health Authority[2] | 28.20 | 34.19 | 58.28 | 55.46 | 66.54 | 242.67 |
| Vancouver Island Health Authority | 7.26 | 8.25 | 11.30 | 10.86 | 12.03 | 49.70 |
| **Total** | **68.93** | **83.76** | **113.50** | **116.27** | **134.24** | **516.69** |

1. Includes BC Emergency Health Services (BCEHS)
2. Includes Providence Health Care and Uninsured Residents Revenue

- Health authority bad debt information for 2020/21 is not yet available as the health authorities are involved in their year-end external audit processes; updated information will be available post-audit when the BC Public Accounts are released.

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**Approved:**
April 27, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Authorities Cash Management and Central Deposit Program

### TOPIC

As a response to the March 2014 report released by the Office of the Auditor General regarding Working Capital Management, the Province will continue to pursue savings through effective governance and financial management of cash across the public sector. For the Ministry of Health, this means continuing to work with health authorities to maximize their cash holdings in Provincial Treasury's Central Deposit Program (CDP).

### CURRENT SITUATION

Health authorities held a total of $1,375.798 million in cash, cash equivalents, and portfolio investments at Quarter 3 of fiscal year 2020/21.

### KEY FACTS

- In March 2014, the Office of the Auditor General released its "Follow-up Report on Working Capital Management" regarding the control of cash in government and more specifically in the schools, universities, colleges and health sector agencies. The report was critical of government generally for failing to more aggressively control how the schools, universities, colleges, and health sector entities accumulate cash since it results in more borrowing and higher costs of borrowing for government. The Office of the Auditor General also reported out on its findings to the Legislative Assembly's Select Standing Committee on Public Accounts on June 25, 2014.
- The Ministry has provided direction that although health authorities are responsible for and must meet the cash requirements necessary to manage their day to day operations, health authorities:
    - shall, as cash equivalents or portfolio investments mature, deposit funds not required for day to day operations in the CDP;
    - shall, to the maximum extent possible, maximize cash holdings within the CDP;
    - shall not make cash withdrawals in support of routine capital or priority initiative capital projects that are not approved and planned for within the Ministry approved Capital Plan; and
    - shall provide quarterly updates to the Ministry regarding their actual and forecast cash, cash equivalents, and portfolio investments for the current fiscal year, as well as, projections for the following two fiscal years.

### FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**
April 27, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Authorities Parking Fees

### TOPIC

All health authorities (HAs) charge for parking at some of their facilities and use parking fee revenue to cover the cost of providing and maintaining parking spaces, with the remainder going to fund direct patient care.

### CURRENT SITUATION

Total Net Revenue across all HAs decreased from $25.117 million in 2018/19 to $19.483 million in 2019/20.

### KEY FACTS

- HAs are responsible for planning, managing and delivering quality health care services, and for operating facilities in their jurisdictions, including parking services.
- In a 2017 review, HAs identified 129 listed hospital facilities across the province and of these, 40 or 31% have pay parking. There are 413 additional HA owned/operated facilities (e.g., residential care facilities, small stand-alone outpatient clinics, etc.) and of these, 69 or 17% have pay parking.
- Although this revenue derived from parking services represents a relatively small proportion of HA operating revenue, parking fee revenues cover the operating costs related to providing safe parking for the public and staff.
- Since 2014/15, HA revenues generated from parking have increased. Some of the reasons include:
    - increase in parking demand and utilization, particularly for acute sites expanding clinical out-patient services thereby increasing the need for short term parking; and
    - increase in parking stall capacity with the expansion of existing facilities, as well as opening of new facilities, such as the Teck Acute Care Centre at the BC Children's and Women's hospitals.
- Parking facilities expenditures include fees to manage the operations of the actual sites, which involves collecting fees, maintaining equipment such as ticket dispensers, general clean-up, repairs, and customer support. Other parking expenditures relate to maintenance costs, which include snow removal, lighting, physical upgrades and significant repairs, sanitation, and other activities to maintain the long-term viability of the parking site. HAs also incur security costs to support their parking sites.
- Vancouver Coastal HA (including Providence Health Care), Fraser HA, and the Provincial Health Services Authorities' parking services are maintained through the Lower Mainland Consolidation agreement. Northern HA, Interior HA, and Vancouver Island HA have slightly different parking management operations and resulting costs, for example the security costs for a parking site may be "bundled" together for an entire hospital site.
- While the revenue generated from fees are used to off-set the costs to operate and maintain parking facilities, fees are also used as a deterrent for non-hospital users using hospital parking spaces, especially in busy high traffic urban areas with limited public parking. Any excess parking revenue supports direct patient care.
- HAs provide financial relief related to parking to some users. Examples include:
    - renal dialysis patients permits are available at no charge due to life-sustaining treatment;
    - family caregiver permits are available at no charge;
    - discounted weekly/monthly passes for frequent hospital visitors/users;
    - free parking for volunteers;
    - financial hardship permits may be available on a case by case basis; and
    - exemption from parking enforcement in situations where visitors are unable to renew their parking time.
- In order to assist in the fight against COVID-19, pay parking was suspended at all HA owned and operated sites starting on April 1, 2020, and continues until further notice.
- The suspension of pay parking has contributed to additional financial pressures for HAs.
- HAs are currently reviewing the need for the implementation of a new pay system, which would allow for greater use of mobile payment options, before reinstating pay parking.
- The Ministry continues to review the parking issue in collaboration with HAs.

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

- HAs reported parking revenue of $39.882 million in 2017/18; $42.228 million in 2018/19; and $40.683 million in 2019/20. The table below details the HA parking revenue and related expenses from fiscal year (FY) 2017/18 to 2019/20.
- HA parking revenue and related expenses for FY 2020/21 are not yet available and will be added once the audited financial statements are completed.

**Health Authorities Parking Revenue 2017/18 to 2019/20 (in $ Millions)**

| | FY 2017/18 | FY 2018/19 | Increase/(Decrease) from 2017/18 (%) | FY 2019/20 | Increase/(Decrease) from 2018/19 (%) |
|---|---|---|---|---|---|
| **FHA** | | | | | |
| Gross Revenue | 14.974 | 15.471 | 3.3% | 14.153 | (8.5%) |
| Management Fees | (1.551) | (1.609) | 3.7% | (1.807) | 12.3% |
| Maintenance | (1.343) | (1.299) | (3.3%) | (1.204) | (7.3%) |
| Other | (1.539) | (1.740) | 13.1% | (1.955) | 12.4% |
| Net Revenue | 10.541 | 10.823 | | 9.187 | |
| **IHA** | | | | | |
| Gross Revenue | 5.328 | 6.037 | 13.3% | 6.127 | 1.5% |
| Management Fees | (0.306) | (0.380) | 24.2% | (0.416) | 9.5% |
| Maintenance | (2.663) | (2.015) | (24.3%) | (2.374) | 17.8% |
| Other | (1.823) | (1.713) | (6.0%) | (3.078) | 79.7% |
| Net Revenue | 0.536 | 1.929 | | 0.259 | |
| **NHA** | | | | | |
| Gross Revenue | 0.985 | 1.034 | 5.0% | 1.062 | 2.7% |
| Management Fees | (0.272) | (0.251) | (7.7%) | (0.257) | 2.4% |
| Net Revenue | 0.713 | 0.783 | | 0.805 | |
| **VCHA** | | | | | |
| Gross Revenue | 5.537 | 5.688 | 2.7% | 5.144 | (9.6%) |
| Management Fees | (2.249) | (2.476) | 10.1% | (2.666) | 7.7% |
| Maintenance | (0.136) | (0.099) | (27.2%) | (0.288) | 191.2% |
| Other | (0.622) | (0.652) | 4.8% | (0.785) | 20.4% |
| Net Revenue | 2.530 | 2.461 | | 1.406 | |
| **VIHA** | | | | | |
| Gross Revenue | 7.889 | 8.159 | 3.4% | 8.323 | 2.0% |
| Management Fees | (1.029) | (1.031) | 0.2% | (1.125) | 9.1% |
| Maintenance | (0.762) | (0.850) | 11.5% | (1.159) | 36.3% |
| Other | (0.710) | (0.659) | (7.2%) | (1.127) | 71.1% |
| Net Revenue | 5.388 | 5.619 | | 4.912 | |
| **PHSA** | | | | | |
| Gross Revenue | 5.169 | 5.839 | 12.9% | 5.874 | 0.6% |
| Management Fees | (0.837) | (1.061) | 26.8% | (1.145) | 7.9% |
| Maintenance | (0.092) | (0.073) | (20.1%) | (0.088) | 20.2% |
| Other | (1.271) | (1.203) | (5.3%) | (1.726) | 43.5% |
| Net Revenue | 2.970 | 3.501 | | 2.915 | |
| **Total Gross Revenue** | **39.882** | **42.228** | **5.9%** | **40.683** | **(3.7%)** |
| Total Management Fees | (6.244) | (6.808) | 9.0% | (7.416) | 8.9% |
| Total Maintenance | (4.996) | (4.336) | (13.2%) | (5.113) | 17.9% |
| Total Other | (5.965) | (5.967) | 0.0% | (8.671) | 45.3% |
| **Total Net Revenue** | **22.678** | **25.117** | | **19.483** | |

Note: Vancouver Coastal HA figures include Providence Health Care.

**Approved:**
May 6, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Interior Health Authority

### TOPIC

The Interior Health Authority (IHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the IHA via the annual Regional Services funding allocation.

### CURRENT SITUATION

IHA had a surplus of $0.362 million in its 2019/20 Audited Financial Statements.

### KEY FACTS

The Ministry's Regional Services funding represents the vast majority of the IHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).

### FINANCIAL IMPLICATIONS

2019/20 Audited Financial Statements of IHA

| | |
|---|---|
| Total Revenues | $2,527.945 million |
| Total Expenses | $2,527.583 million |
| Surplus (Deficit) | $ 0.362 million |

2019/20 Breakdown of Total Revenues by Major Funding Source
Year ended March 31, 2020
($ Millions)

| | Budget | 2020 | 2019 |
|---|---|---|---|
| **Revenues** | | | |
| Ministry of Health Contributions | 1,999.867 | 2,023.926 | 1,854.262 |
| Medical Services Plan | 162.729 | 167.061 | 162.684 |
| Patients, clients and residents | 113.510 | 114.357 | 114.188 |
| Amortization of deferred capital contributions | 80.848 | 89.232 | 79.777 |
| Recoveries from other health authorities and BC government reporting entities | 57.607 | 56.588 | 46.159 |
| Other contributions | 35.736 | 36.038 | 37.611 |
| Other revenues | 35.971 | 37.815 | 33.480 |
| Investment income | 2.159 | 2.928 | 3.176 |
| | 2,488.427 | 2,527.945 | 2,331.337 |

Note: Amounts as per the 2019/20 audited financial statements.

Regional Services Funding Allocation (To IHA from Ministry)

2017/18 - $1.750 billion (per 2017/18 Final Funding Letter)
2018/19 - $1.859 billion (per 2018/19 Final Funding Letter)
2019/20 - $2.028 billion (per 2019/20 Final Funding Letter)

Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

Estimated Full-Time Equivalents (FTEs)

According to Health Sector Compensation Information System 2019 Quarter 4 data, the estimated number of FTEs is as follows:

Unionized – 13,976

Non-unionized/Management – 1,170

Government Financial Information

IHA Population

- According to BC Stats, IHA's population forecast and rate of growth is as follows:
  - 2020/21 – 0.841 million, 0.69% growth
  - 2021/22 – 0.847 million, 0.81% growth
  - 2022/23 – 0.855 million, 0.88% growth
- As of November, 2020, approximately 23.7% of IHA's population is age 65 and over.

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**Approved:**

June 3, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Langley Memorial Hospital Emergency Department Redevelopment

## TOPIC

Update on the status of the Langley Memorial Hospital (LMH) Emergency Department (ED) Redevelopment project (the Project).

## CURRENT SITUATION

Construction is underway. Substantial completion of the new building is scheduled for March 2021.

## KEY FACTS

Scope

The Project includes a single-story expansion to the east of the existing LMH ED, including the following:

- Increased treatment spaces from 31 to 49 (including 2 dedicated Mental Health and Substance Use spaces);
- Increased ED space from 970m$^2$ to 2,356m$^2$ and a lobby expansion of 235m$^2$;
- Reconfiguration of the main entrance for a clear and separate identity for the ED upon entering from the east;
- Creating a new after-hours, controlled access point into the main hospital that does not require patients/visitors to go through the clinical ED space; and
- Creating an additional 970m$^2$ (vacated space) for future use within LMH.

Budget

| Funding Sources | Project Costs ($millions) | % of Total Project Cost |
|---|---|---|
| Langley Memorial Foundation | 10.00 | 25% |
| Fraser Health Authority Internal Funding | 29.32 | 75% |
| **Total Project Cost** | **$39.32** | **100%** |

Schedule

| Milestone | Date |
|---|---|
| Treasury Board Approval of Business Plan | March 2017 |
| Design and Planning | April 2018 |
| Tender & Award | November 2018 |
| *Announcement of Construction Start* | *January 25 2019* |
| Substantial Completion (New Building) | March 2021 |
| Construction Completion of Full Project | April 2021 |
| Open to Patients | May 4, 2021 |

Background

- LMH is a full-service hospital that consists of 192 inpatient beds and an extensive range of services, including intensive care, cardiac, patient assessment, and transition to home, surgical, electroconvulsive therapy, mental health and substance use, maternity, paediatrics, outpatient services, residential care, and hospice.
- The current ED opened in 1986, with an area of 970m$^2$ and was designed to serve approximately 25,000 visits annually.
- Based on current standards and projections, the ED is significantly undersized.
- In 2015/16, ED visits increased to over 46,000, and by 2030 annual visits are projected to be approximately 60,000; an increase of 140% from the original design expectations.
- In 2015, a High-Level Master Plan (HLMP) was completed by LMH. This plan identified the ED redevelopment as a high priority due to population growth, non-compliance with infection control standards/measures, and safety risks.
- In February 2017, Fraser Health Authority (FHA) submitted the final Business Plan to the Ministry of Health.

- In March 2017, the ED Redevelopment Project was approved by Treasury Board.
- On May 24, 2017, funding for the ED Redevelopment Project was added to the Capital Plan.
- In March 2018, a Quantity Surveyor "Class C" cost estimate provided an updated total capital cost of $39.32 million. The higher cost was due to changes in market conditions in the construction industry and design refinements.
- In July 2018, Treasury Board approved a $9.26 million increase in total capital costs from $30.06 million to $39.32 million, to be funded by FHA.
- Start of construction was announced on January 25, 2019.

## FINANCIAL IMPLICATIONS

N/A

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**Approved by:**
March 4, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Mills Memorial Hospital Replacement

## TOPIC

Update on the Mills Memorial Hospital (MMH) Replacement.

## CURRENT SITUATION

Government Financial Information

- The project team engaged a consultant to assess the requirement for a workers' camp and confirmed that a worker's camp would be the best solution to house the workforce.

Government Financial Information

## KEY FACTS

Scope

The approved Business Plan includes:

- A new 2-storey hospital expected to be more than twice the size of the current facility, going from 11,610 $m^2$ to approximately 26,400 $m^2$;
- 78 inpatient beds featuring private rooms - a net increase of 34 beds;
- An expanded emergency department, including 2 trauma bays, 6 stretcher bays, pediatric care space and 4 operating rooms, as well as the latest diagnostic imaging equipment;
- A Level III trauma centre and orthopaedic surgery centre for the Northwest; and
- Modern mental health service delivery with a new and larger 25-bed Seven Sisters regional mental health facility that provides access to outdoor spaces for patients. The new MMH will also improve mental health services, with 20 of the 78 beds dedicated to adult inpatient psychiatric care.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Ministry of Health | 337.30 | 75% |
| North West RHD | 110.20 | 25% |
| **Total Project Cost** | **$447.50** | **100%** |

Schedule

| Milestone | Date |
|---|---|
| Concept Plan Approval | January 2018 |
| *Announcement of Concept Plan Approval* | *February 2018* |
| Business Plan Approval | May 2019 |
| *Announcement of Business Plan Approval* | *May 2019* |

Cabinet Confidences; Government Financial Information

| | |
|---|---|
| Construction Start | April/May 2021 |
| Construction Substantial Completion | February 2025 |
| **Open for Patients*** | **May 2025** |

*Schedule is subject to change depending on when DBA is executed – see Current Situation

# LEGISLATIVE SESSION - FACT SHEET

Background

- MMH was constructed in 1959 with a major expansion in 1975. It is a fully accredited acute care facility serving Terrace and its surrounding area. The hospital provides 24/7 access to services that include a psychiatric unit, inpatient units, surgical suites, an ICU, and an extensive day-care service.
- The 1959 facility contains undersized operating rooms that limit the number and scope of surgeries performed. In addition, the layout does not provide good separation between inpatients and ambulatory services and infection control is difficult due to challenges in strictly separating sterile from dirty equipment.
- MMH delivers health care services to the entire northwest region of the province, including medical and general surgical services, emergency care, ambulatory services and visiting specialist programs.
- As part of Budget 2017, the Ministry of Finance (MoF) added notional capital funding for the replacement of MMH to the Ministry of Health's (the Ministry) Capital Plan, and MoF requested the submission of an updated Concept Plan by November 2017.
- On February 9, 2018, Minister Adrian Dix announced the Concept Plan was approved and the project would be moving to the business planning stage.
- In December 2018, NHA completed the Business Plan and submitted it to the Ministry. The Business Plan included the complete replacement of the existing 44-bed MMH on the northern portion of the existing site. The existing Seven Sisters mental health facility will also be replaced on site, and the existing Seven Sisters and the Sleeping Beauty medical clinic will be demolished.

Advice/Recommentations; Government Financial Information

## FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Ministry of Health Historical Capital Spending

### TOPIC

Capital funding provided to the health authorities by the Ministry of Health from 2001/02 to 2019/20.

### CURRENT SITUATION

- The Ministry provides health authorities with capital funding from different sources. Prior to April 1, 2009, debt-financed capital was provided through Prepaid Capital Advances (PCA). Effective April 1, 2009, PCAs were replaced by Restricted Capital Grants (RCG). This funding is now provided through the Capital Funding vote in Other Appropriations.
- Since 2004/05 the province has also provided health capital on major projects through Public Private Partnerships (P3).
- Non-RCG funding is provided through the Ministry's operating vote for minor capital under $100,000 (construction, equipment and IM/IT) and maintenance expenses.
- In addition to funding provided by the Ministry, health authorities obtain capital funding from own-source revenues, Regional Hospital Districts (RHD), hospital foundations and auxiliaries and other third parties.
- Capital funding provided to health authorities by the Ministry from 2001/02 to 2019/20 (last fully completed fiscal year) is summarized in the table in the Key Facts section below.

### KEY FACTS

The following table summarizes capital funding provided to health authorities by the Ministry since 2001/02. It does not include capital contributions from other funding sources (i.e. RHDs, Foundations or health authority own-source revenues).

**SUMMARY OF PROVINCIAL CAPITAL SPENDING FROM 2001/02 to 2019/20**

($ in millions, rounded)

Government Financial Information

## FINANCIAL IMPLICATIONS

- The following table identifies health sector capital spending as reported from all sources (i.e. Ministry funding, RHDs, foundations, auxiliaries, and health authorities own source revenues).

**HISTORICAL HEALTH SECTOR CAPITAL SPENDING**

**Budget vs Actual**

($ in millions)

| Fiscal Year | 01/02[1] | 02/03[1] | 03/04[1] | 04/05[1] | 05/06[1] | 06/07[2] | 07/08[2] | 08/09[2] | 09/10[2] | 10/11[2] | 11/12[2] | 12/13[2] | 13/14[2] | 14/15[2] | 15/16[2] | 16/17[2] | 17/18[2] | 18/19[3] | 19/20[3] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Budget** | N/A | N/A | N/A | 326 | 756 | 666 | 819 | 924 | 1,025 | 1,161 | 841 | 879 | 886 | 847 | 983 | 1,193 | 1,218 | 1,107 | 1,255 |
| **Actual** | 275 | 422 | 420 | 568 | 848 | 760 | 881 | 892 | 927 | 916 | 732 | 742 | 690 | 900 | 923 | 1,004 | 890 | 904 | 1,009 |
| **Variance - over/ (under)** | N/A | N/A | N/A | 242 | 92 | 94 | 62 | (32) | (98) | (245) | (109) | (137) | (196) | 53 | (60) | (189) | (328) | (203) | (246) |

1. 2001/02 - 2005/06 - Actual as reported in 2013 Financial and Economic Review - August 2013 (Table A2.10).
2. 2006/07 - 2017/18 - Actual as reported in 2018 Financial and Economic Review - August 2018 (Table A2.10, page 97)
3. 2018/19 - 2019/20 - Actual as reported in 2020 Financial and Economic Review - September 2020 (Table A2.9, page 105)

- Comparable information for health sector capital spending is not available prior to 2002/03 when the regional health authority structure was implemented. Health sector capital forecasts and variances are not available prior to 2004/05.
- For the fiscal years from 2001/02 to 2019/20, total health sector capital spending was approximately $15 billion.

**Total Health Sector Capital Spend (includes all funding sources)**

($ in millions)

| Fiscal Year | 01/02[1] | 02/03[1] | 03/04[1] | 04/05[1] | 05/06[1] | 06/07[2] | 07/08[2] | 08/09[2] | 09/10[2] | 10/11[2] | 11/12[2] | 12/13[2] | 13/14[2] | 14/15[2] | 15/16[2] | 16/17[2] | 17/18[2] | 18/19[3] | 19/20[3] | Total 01/02 - 19/20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Actuals** | **275** | **422** | **420** | **568** | **848** | **760** | **881** | **892** | **927** | **916** | **732** | **742** | **690** | **900** | **923** | **1,004** | **890** | **904** | **1,009** | **14,703** |

1. 2001/02 - 2005/10 - Actual as reported in 2013 Financial and Economic Review - August 2013 (Table A2.10).
2. 2006/07 - 2017/18 - Actual as reported in 2018 Financial and Economic Review - August 2018 (Table A2.10, page 97)
3. 2018/19 - 2019/20 - Actual as reported in 2020 Financial and Economic Review - September 2020 (Table A2.9, page 105)

- For the next 3-year period (2020/21 to 2022/23), health sector capital spending is estimated to be approximately $6.4 billion based on the Q3 2019/20 submission to the Ministry of Finance used for Budget 2020.

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**Approved:**
March 4, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Ministry Spending Directives

### TOPIC

Government has introduced spending directives in order to manage costs and the overall budget efficiently. The spending directives are available as a link on the Ministry of Health's (the Ministry) intranet for all employees to view.

### CURRENT SITUATION

The Ministry continues to monitor expenditures to ensure they adhere to the spending directives and continue to provide value for money.

### KEY FACTS

- The Finance and Corporate Services Division has issued directives to meet budget targets. These directives include:
    - Operating Expenses (May 2021)
    - Travel – In-Province and Out-of-Province (May 2021)
    - Travel Addendum (May 2021)
    - Mobile Devices (May 2021)
    - Electronic Storage – Shared Drive / Email / Personal Drive Storage (May 2021)
    - Single Workstation, Printing, Faxing, Copying and Scanning (May 2021)
- Directives that are currently being updated include:
    - Contract Management (targeted May 2021)
    - Salary Expenses (targeted May 2021)
    - Transfer Payments (targeted May 2021)
    - Telephone Expenses (targeted May 2021)

Background

Ministries are expected to manage discretionary spending in order to achieve budget targets and consider how expenditures could be made differently and less expensively. To achieve this, the Ministry issues spending directives aimed at reducing expenditures in administrative areas.

### FINANCIAL IMPLICATIONS

Compliance with these directives has been monitored.

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**Approved:**

May 10, 2021 - Peter Klotz, A/CFO, Finance and Corporate Services Division
June 3, 2021 - Philip Twyford, ADM, Finance and Corporate Services

# LEGISLATIVE SESSION - FACT SHEET

## New St. Paul's Hospital

### TOPIC

Status of the New St. Paul's Hospital (SPH) project (the Project) in Vancouver.

### CURRENT SITUATION

- Marketing of the current SPH land at 1081 Burrard Street started February 15, 2019, and the approval process has been completed for a Sale Agreement with Concord Pacific. On July 31, 2020; all vendor conditions were removed, and the sale finalized.
- A rezoning application for the Station Street site was submitted to the City of Vancouver in August 2018 and approved by Vancouver City Council on November 5, 2019.
- Evaluation of the proponent technical submissions has been completed and requests were issued to the 2 proponents (Ellis Don and PCL) to submit financial proposals.
- Financial proposals were submitted November 25, 2020, and Financial Close is targeted for February 2021.

### KEY FACTS

Scope

- The new SPH at the Station Street site will continue to serve the people of Vancouver and all of BC as an internationally renowned, full-service acute-care hospital and integrated health campus.
- It will have capacity for up to 548 beds, which includes 115 net new beds.
- The site will be the home of several leading provincial programs and referral centres including heart and lung care, renal, eating disorders, and specialty surgeries and transplants.
- The new hospital will also offer a diverse and long list of general and specialized care including HIV/AIDS, chronic disease management services, emergency and critical care, mental health and addictions beds and programs, ambulatory services and outpatient clinics, end-of-life care, Indigenous health, maternity, colorectal and gastrointestinal services, and community care and community outreach programs.
- The new SPH will continue to be a teaching hospital - training hundreds of University of British Columbia medical students, BC Institute of Technology nursing students, and hundreds of other health sector professions.
- The total space required for the new SPH (Phase 1a of development on the Station Street site), including parking, is estimated at 187,933 building gross $m^2$ (over 2 million $ft^2$).
- A second phase of development on the Station Street site (Phase 1b) includes the Clinical Support and Research Centre, which will accommodate clinicians and researchers on the campus.

Advice/Recommentations

- Detailed business planning is underway for Phase 1b and is expected to complete in March 2021.

Budget

| Funding Sources | Project Costs ($ millions) | % of Total Project Cost |
|---|---|---|
| Ministry of Health | 1,158 | 56% |
| Providence Health Care | 800 | 38% |
| St. Paul's Hospital Foundation | 125 | 6% |
| **Total Project Cost** | **$2,083** | **100%** |

Schedule

- The project will be delivered using a Design-Build-Finance procurement model with 10% short-term private financing.
- The Request for Qualifications (RFQ) resulted in 2 shortlisted proponents (PCL and EllisDon). A preferred proponent is expected to be confirmed in February 2021.
- The new SPH is planned to open in 2027. This will be confirmed based on the schedule provided by the successful proponent from the procurement process.

# LEGISLATIVE SESSION - FACT SHEET

| Milestone | Date |
|---|---|
| Business Plan Approval and Announcement | February 2019 |
| Issue RFQ | May 2019 |
| Issue RFP | September 2019 |
| Construction Start | March 2021 |
| Construction Substantial Completion | July 2026 |
| **Open for Patients** | **January 2027** |

Station Street Site Acquisition

- In December 2015, PHC exercised its option to purchase the 18.4-acre Station Street site in the False Creek Flats area of Vancouver from the Vancouver Esperanza Society.
- The purchase price was $24.8 million plus closing costs. VCHA provided a loan to PHC for the property purchase.

Background

- SPH is a 435-bed acute care, academic and research hospital located in downtown Vancouver. The facility is owned and operated by PHC within the Vancouver Coastal Health Authority. SPH provides approximately 2% of all acute care services in the health authority. Parts of SPH are more than 100 years old and require capital redevelopment to allow SPH to meet future patient needs.
- On April 13, 2015, PHC announced plans for a new SPH and health care campus to be located at the 18.4-acre Station Street site in Vancouver which is 2.9 km from the current SPH location - an 8-minute drive by car (10 minutes in traffic).
- Design consultants were selected to assist with facility planning and design for the new hospital and, in July 2017, PHC completed a Policy Planning Statement with the City of Vancouver that will guide planning, development, and rezoning of the Station Street site.
- The SPH Redevelopment Business Plan was received by the Ministry of Health (the Ministry) on January 31, 2018. The Ministry and PHC reviewed opportunities to reduce the capital cost and confirm the appropriate clinical scope, which was incorporated into a final Business Plan and submitted by PHC to the Ministry in early June 2018.

## FINANCIAL IMPLICATIONS

- The approved budget for the new SPH is $2.083 billion Government Financial Information
Government Financial Information
- The Project will be cost-shared, with the Province funding $1.158 billion (included in the Ministry's current 10-Year Capital Plan), PHC funding $800 million, and the St. Paul's Foundation providing $125 million.

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**Approved:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Northern Health Authority

### TOPIC

The Northern Health Authority (NHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the NHA via the annual Regional Services funding allocation.

### CURRENT SITUATION

NHA had a surplus of $2.411 million in its 2019/20 Audited Financial Statements.

### KEY FACTS

- This Ministry's Regional Services funding represents the vast majority of the NHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, preferred accommodation, etc.).
- Wrinch Memorial Hospital in Hazelton became part of the NHA on April 1, 2016 and was included in the NHA's audited financial statements in 2016/17. Wrinch Memorial Hospital was previously a denominational affiliate. Denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements. The Ministry does not provide Regional Services operating funding directly to the denominational affiliate; the NHA is responsible for allocating operating funding to the denominational affiliate. The financial results of the NHA and the denominational affiliates are consolidated in the Government Reporting Entity.

### FINANCIAL IMPLICATIONS

2019/20 Audited Financial Statements of NHA

| | |
|---|---|
| Total Revenues | $949.422 million |
| Total Expenses | $947.011 million |
| Surplus (deficit) | $ 2.411 million |

2019/20 Breakdown of Total Revenues by Major Funding Source
Year ended March 31, 2020
($ Millions)

| | Budget | 2020 | 2019 |
|---|---|---|---|
| **Revenues** | | | |
| Ministry of Health Contributions | 689.300 | 706.393 | 651.247 |
| medical Services Plan | 102.000 | 100.431 | 98.805 |
| Amortization of deferred capital contributions | 47.700 | 46.469 | 48.580 |
| Patients, clients and residents | 45.300 | 44.542 | 43.636 |
| Other contributions | 17.000 | 16.831 | 19.027 |
| Recoveries from other health authorities and BC government reporting entities | 12.400 | 13.619 | 13.025 |
| Investment income | 1.400 | 0.980 | 1.421 |
| Other revenues | 12.800 | 20.157 | 16.913 |
| | 927.900 | 949.422 | 892.654 |

Note: Amounts as per 2019/20 audited financial statements.

# LEGISLATIVE SESSION - FACT SHEET

Regional Services Funding Allocation

2017/18 - $621.078 million (per 2017/18 Final Funding Letter)
2018/19 - $652.177 million (per 2018/19 Final Funding Letter)
2019/20 - $712.074 million (per 2019/20 Final Funding Letter)
Government Financial Information

Estimated Full-Time Equivalents (FTEs)

According to Health Sector Compensation Information System 2019 Quarter 4 data, the estimated number of FTEs is as follows:

Union – 5,090
Non-Union/Management - 541

Government Financial Information

NHA Population

- According to BC Stats, the NHA's population forecast and rate of growth is as follows:
    - 2020/21 – 0.289 million, 0.77% growth
    - 2021/22 – 0.292 million, 0.89% growth
    - 2022/23 – 0.295 million, 0.96% growth
- As of November, 2020, approximately 14.9% of NHA's population is age 65 and over.

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**Approved:**
June 3, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Peace Arch Hospital Renewal Project

## TOPIC

Status of the Peace Arch Hospital (PAH) Renewal project (the Project) in White Rock.

## CURRENT SITUATION

- The Project is currently under construction.
- The Project is forecasting a schedule delay of 5 months from the construction schedule (in addition to previous tender delay), resulting from various risks and issues that have materialized during construction. Substantial completion of the new building is expected in September 2021, with renovations for the Emergency Department Mental Health Unit expected to be completed by August 2022.

## KEY FACTS

Scope

The Project is a 3-level expansion that involves 3 components:

- Medical Device Reprocessing Department (MDRD) relocation/redevelopment – Level 0
  - Relocate and expand the MDRD in a newly constructed space below the Emergency Department (ED) of 1,151 $m^2$;
  - Installation of new dedicated elevators with direct access to the Operating Rooms (OR); and
  - Implementation of a closed case-cart transportation system and purchase and installation of medical device reprocessing equipment (e.g., sterilizers).
- ED expansion and renovations – Level 1
  - Expansion of the existing ED from 764 $m^2$ to 2,131 $m^2$;
  - Expansion from 24 to 50 treatment spaces, including 2 resuscitation bays and 9 reclining treatment chairs; and
  - Dedicated mental health unit with external access, 2 isolation rooms with antechambers, and dedicated decontamination space to address hazardous substance contamination and infection control risks.
- Perioperative Suite (PS) expansion/redevelopment – Level 2
  - Additional care space will be created on Level 2 above the ED expansion space;
  - 5 ORs consisting of 55 $m^2$ each will comply with current standards;
  - Post Anaesthetic Care Unit for recovery of Stage I OR patients;
  - Perioperative Care Unit – space to accommodate patient/family reception, patient preparation and Stage II recovery; and,
  - Clinical, auxiliary and staff support spaces.

Project Board Scope Change:

- On September 18, 2020, the Fraser Health Authority (FHA) Capital Project Board approved the addition of 3 anterooms to the project scope (emergency trauma (1) and perioperative suite (2) to optimize patient and staff safety in support of workplace health and safety and infection control best practices, in response to COVID-19.

Budget

The total approved project cost by funding sources is as follows:

| Funding Sources | Project Costs $ millior | % of Total Project Cos |
|---|---|---|
| Peace Arch Hospital Foundation | 38.50 | 42.28% |
| Fraser Health Authority Internal Sources | 44.35 | 48.71% |
| Provincial Routine Capital | 8.20 | 9.01% |
| **Total Project Cost** | **$91.05** | **100%** |

# LEGISLATIVE SESSION - FACT SHEET

Schedule

| Milestone | Date |
|---|---|
| Government Approval | March 2017 |
| *Announcement of Business Plan Approval* | *April 5 2017* |
| Request for Qualifications (RFQ) Issuance | June 2018 |
| Request for Proposals (RFP) Issuance | September 2018 |
| Construction Start | December 2018 |
| New Building (MDRD/ED/Perioperative Suite) - Substantial Completion | September 2021 |
| New Building Open to Patients | October 2021 |
| Existing ED Demolition | November 2021 |
| New Mental Health Unit - Substantial Completion | June 2022 |
| New Mental Health Unit Open to Patients | June 2022 |

Background

- The PAH is a community hospital located in White Rock that provides emergency services, inpatient acute care services, surgical services, critical care, maternity care, outpatient services, medical imaging, and laboratory services.
- In 2012, FHA completed a Master Plan for PAH that identified an expansion of the ED as a top priority.
- In 2013, FHA submitted a Business plan for a $20 million ED expansion project and was approved to proceed with the project in December 2014.
- In spring 2016, FHA informed the Ministry of Health that they were proposing to add 2 more components to this project: 1) Medical Device Reprocessing Department relocation; and 2) Surgical Suite expansion
- In February 2017, FHA submitted a final Business Plan to the Ministry including all 3 components.
- In March 2017, the $68.23 million project was approved by government and on April 5, 2017, government announced approval of the Business Plan.
- In September 2017, the project made its first appearance in the Over 50 Million Table, with the Budget 2017 update.
- In April 2018, a Quantity Surveyor "Class C" cost estimate provided an updated total capital cost of $83.68 million. The higher cost was due to changes in market conditions in the construction industry and design refinements.
- In July 2018, Treasury Board approved a $15.45 million increase in total capital cost from $68.23 million to $83.68 million to be managed by FHA.
- Once construction tenders were received, the construction schedule was adjusted to more accurately reflect the current market conditions and project size, and to account for delays in procurement, soil contamination removal, air handling unit delay, and temporary seclusion room delay; and additional contractor delay during construction extending the period by approximately 79 weeks.
- The FHA prepared a cost refresh in September 2020 to address higher construction costs due to site discoveries, complex tie ins and learnings from COVID-19. This refresh resulted in an additional $7.37 million (8.8% increase) being added to the project cost for a revised total capital cost of $91.05 million.

## FINANCIAL IMPLICATIONS

In January 2021, Treasury Board approved a $7.37 million increase in total capital costs from $83.68 million to $91.05 million. The cost increase will be funded by FHA internal sources ($5.87 million) and the PAH Foundation ($1.50 million).

**Approved by:**
March 4, 2021 - Philip Twyford, ADM, Finance and Corporate Services

# LEGISLATIVE SESSION - FACT SHEET

## Population Needs-Based Funding for Health Authorities

### TOPIC

The Population Needs-Based Funding (PNBF) model is a funding methodology to determine how to divide a pre-determined pool of funds fairly and equitably between the 5 regional health authorities. The Ministry of Health retained KPMG and Preyra Consulting to undertake a review of the model. The review was completed by the end of February and KPMG completed follow-on, related funding analytical work by the end of March 2015. Ministry staff and representatives from the health authorities formed a working group reporting to the Standing Committee on Finance and Corporate Issues (SCFCI) to review the report recommendations and implement possible changes to the model.

### CURRENT SITUATION

The model has been updated with the most recent population adjsutments and has been used in determining funding allocations to health authorities for the 2020/21 to 2022/23 budget cycle.

### KEY FACTS

- The Ministry's PNBF model is used to allocate funding to the Interior, Fraser, Vancouver Coastal, Vancouver Island, and Northern health authorities and is based on models for the acute care and home and community care (residential and community services) sectors.
- The PNBF model is not used to allocate funding to the Provincial Health Services Authority (PHSA). Funding for the PHSA is based on historical funding levels and the estimated growth of specialized provincial services such as transplant, renal, cancer, and cardiac care (life support programs).
- The model was originally developed by the Ministry in 2002, it was reviewed and endorsed by an external group of academics in that year, by IBM in November 2004 and a joint Ministry/Health Authority Funding Methodology Review in 2004, and a review by external consultants in 2005/06. Population-based funding allocation methods are used in other jurisdictions including: Wales, Scotland, New Zealand, Saskatchewan, Ontario, etc. There is international recognition that developing funding models is complex, especially adjusting for regional costs.
- PNBF takes the following factors into consideration in determining funding allocations:
    - Population Demographics – the size, demographic composition and rate of change of regional populations by age, gender and socio-economic status determine the need for health care services.
    - Utilization – The utilization of health care services in the BC population varies significantly by age, gender, and socio-economic status and is estimated for each health authority.
    - Inter-Regional Flows – Since residents can receive services in other health authorities, the model reallocates workload to the health authorities providing the services.
    - Regional Costs – Adjustments are made to recognize the differences in the cost of delivering health care in the regions due to remoteness or the higher costs inherent in large, specialized acute care facilities.
- The Ministry has updated the model for 2011/12, 2012/13, 2013/14, and in the current review using its "Health System Matrix" approach:
    - The Ministry has developed an approach that identifies the actual health status of BC residents that incorporates major chronic conditions and information about health status that can be inferred from diagnoses and use of health care services.
    - Can assign every BC resident to one of 13 health status groups.
    - Analysis has shown that in the PNBF model the Health System Matrix health status groups are better at explaining health care utilization than the former SES groups.
- Inter-Regional Flows – since residents can receive services in other health authorities, the PNBF model can reflect a redistribution of workload that effectively reallocates funds to the health authorities providing the services; however, the data limitations discussed previously did not make workload redistribution possible in 2009/10 or 2010/11 model calculations.

- Regional Costs – adjustments are made to PNBF allocations for differences in the cost of delivering health care in different regions due to remoteness or the higher costs inherent in large, specialized acute care facilities (complexity).
- The role of a funding model is to provide a transparent, understandable, and practical methodology for allocating specific funds among health authorities. The model does not:
    - determine the Ministry budget or amount of health resources needed;
    - allocate funding for provincial-level services or the PHSA;
    - allocate funding for health services not provided by health authorities (MSP Physician Services, BC Ambulance, PharmaCare); and
    - specify how the health authorities should spend their funds. Health authorities receive global funding and may move funds between sectors, as long as they meet the Ministry's expectations for the delivery of services as outlined in policies, standards of care, and performance agreements with the Ministry.
- Because the PNBF allocations include adjustments for patient flow between health authorities and other regional variations, it is not appropriate to use the funding allocations to produce per capita funding statistics.
- The working group completed its analytical work and made its recommendations to change the model to SCFCI. SCFCI approved the working group recommendations and the Ministry implemented the changes to the model.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
April 27, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Private Clinics

### TOPIC

Health care services in BC have long been provided through a mix of public, non-profit and private for-profit providers. Private for-profit providers include privately owned residential care facilities, community pharmacies, and physician practices, including surgical clinics.

### CURRENT SITUATION

In 2019/20, there were 12,336 surgical cases completed at contracted sites across the province.

### KEY FACTS

- Since 2002, Ministry of Health policy[1] has allowed health authorities (HAs) to purchase outpatient clinical services from private diagnostic and medical/surgical clinics, in addition to providing these services directly, as long as quality, cost-effectiveness and accountability requirements are met. This change does not represent creation of a second tier of health care funded on a private-pay basis. Health care services delivered through contracts with private clinics are fully funded by government, as required by the *Canada Health Act*[2]. The Medical Services Plan (MSP) pays the physician fees associated with such services, while the HAs fund facility costs for contracted services.
- Quality of care for purchased services is the responsibility of both the College of Physicians and Surgeons of BC (the accreditation and regulatory body) and the contracting HA. The Patient Service Delivery Policy is being used by HAs to provide short-term relief for capacity pressures; and to re-direct less complex surgical procedures so that hospital operating rooms are available to deal with more complex, priority procedures, such as hip and knee replacements.
- In addition to health authority sites, in 2019/20 there were 11 private surgical centres that HAs contracted in compliance with the *Canada Health Act* to perform surgeries. The Provincial Health Services Authority (PHSA) does not have any contracts for private surgeries.
- In 2020/21 there are 8 private surgical centres under contract with the HAs.
- The types of surgeries contracted out to private surgical centres include cataracts, dentistry, ENT procedures, neurosurgery, plastic surgery, ophthalmology, orthopedics and many others. These are all considered day care procedures, and the patient length of stay at the facility may be no more than 24 hours following a procedure. HAs have provided a copy of current contracts and confirmation of payments for 2019/20.
    - 2016/17: 9,948 contracted day surgical cases[3] (3.1%) out of 318,833 total day surgical cases.
    - 2017/18: 9,355 contracted day surgical cases[3] (2.9%) out of 322,487 total day surgical cases.
    - 2018/19: 11,607 contracted day surgical cases[3] (3.5%) out of 335,493 total day surgical cases.
    - 2019/20: 12,336 contracted day surgical cases[3] (3.7%) out of 337,063 total day surgical cases.

Advice/Recommentations

### FINANCIAL IMPLICATIONS

The total amount paid by HAs in 2019/20 to private clinics for acute care services was $21.4 million[4]; 0.20% of the $10.9 billion HAs reported spending in acute care in the same time period (source: 2019/20 audited HA financial statements).

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**Approved:**
February 21, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

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[1] Patient Service Delivery Policy - Communiqué 2002-37
[2] *Canada Health Act https://laws-lois.justice.gc.ca/eng/acts/C-6/ last amended on 2017-12-12*
[3] Surgical Services in British Columbia Program Profile Updated 2020.08.31, Health Services Division, the Ministry of Health
[4] Excludes PHSA. PHSA does not have any contracts for private surgeries.

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Health Services Authority

### TOPIC

The Provincial Health Services Authority (PHSA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the PHSA via the annual Regional Services funding allocation.

### CURRENT SITUATION

PHSA had a surplus of $0.375 million in its 2019/20 Audited Financial Statements.

### KEY FACTS

- The Regional Services funding represents the vast majority of the PHSA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, other health authorities, foundations, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking and preferred accommodation).
- The PHSA is responsible for:
    - Planning in conjunction with regional health authorities, and in some cases providing direct funding, for specialized services, including cardiac services and programs; thoracic surgery; trauma services; Centre for Excellence in HIV/AIDS; and BC Autism Assessment Network.
    - Providing leadership and coordination, in conjunction with the Ministry on several system improvements in emergency care, surgical services, and specialized neonatal care.
    - Corporate governance and management for provincial agencies and services, including BC Cancer; BC Centre for Disease Control; BC Renal; BC Transplant; BC Mental Health and Substance Use; BC Women's Hospital and Health Centre; BC Children's Hospital and Health Centre; BC Children's Hospital and Sunny Hill Health Centre; and PHSA Cardiac Services BC.

### FINANCIAL IMPLICATIONS

2019/20 Audited Financial Statements of PHSA

| | |
|---|---|
| Total Revenues | $3,863.921 million |
| Total Expenses | $3,863.546 million |
| Surplus | $ 0.375 million |

2019/20 Breakdown of Total Revenues by Major Funding Source
Year ended March 31, 2020
($ Millions)

| | Budget | 2020 | 2019 |
|---|---|---|---|
| **Revenues** | | | |
| Ministry of Health Contributions | 2,540.664 | 2,642.643 | 2,482.632 |
| Recoveries from other health authorities and BC government reporting entities | 534.154 | 614.793 | 577.458 |
| Medical Services Plan | 204.860 | 212.533 | 204.962 |
| Other contributions | 108.612 | 116.004 | 115.761 |
| Amortization of deferred capital contributions | 98.906 | 91.136 | 92.423 |
| Research and designated contributions | 87.388 | 100.727 | 88.863 |
| Other revenues | 33.815 | 54.691 | 44.072 |
| Patients, clients and residents | 15.540 | 21.775 | 21.983 |
| Pharmacare | 5.550 | 6.794 | 6.092 |
| Investment income | 2.233 | 2.825 | 2.940 |
| | 3,631.722 | 3,863.921 | 3,637.186 |

Note: Amounts as per 2019/20 audited financial statements, and do not include Operating Summary (revenues and expenses) for PHSA Agencies.

# LEGISLATIVE SESSION - FACT SHEET

Regional Services Funding Allocation

2017/18 - $2.239 billion (per 2017/18 Final Funding Letter)
2018/19 - $2.429 billion (per 2018/19 Post Final Funding Letter Update #2)
2019/20 - $2.555 billion (per 2019/20 Final Funding Letter)

Government Financial Information

Estimated Full-Time Equivalents (FTEs)

According to Health Sector Compensation Information System 2018 Quarter 4 data, the estimated number of FTEs is as follows:

Union – 10,731
Non-Union/Management – 3,653

Government Financial Information

- As of fiscal year 2018/19, the PHSA does not prepare separate financial statements, as these agencies are no longer separate legal entities.

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**Approved:**
June 3, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Red Fish Healing Centre for Mental Health and Addiction Project

## TOPIC

Update on the Red Fish Healing Centre (RFHC) (previously named Centre for Mental Health and Addictions [CMHA] Replacement project).

## CURRENT SITUATION

- Construction work is underway. The building exterior cladding is well advanced, mechanical, and electrical services are continuing, and interior and finishing trades are progressing.
- Provincial Health Services Authority (PHSA) will enter a land lease with BC Housing for the land underlying the RFHC building footprint on the previously named Riverview site. The Riverview Lands have been renamed səmiq̓ʷəʔelə (pronounced Suh-MEE-kwuh-EL-uh), which means 'The Place of the Great Blue Heron' in the həńq̓əmiṅəm language of the Kwikwetlem First Nation people. The renaming is in recognition and respect for the Kwikwetlem First Nations' historical and cultural ties to its ancestral land.
- Pending finalization of the land lease, a temporary occupancy agreement (license) was granted to permit PHSA to access the site and construct the RFHC, but not to occupy until the land lease is finalized.

## KEY FACTS

Scope

- The RFHC project is a new 105-bed, 20,800 m² tertiary mental-health facility being constructed on the səmiq̓ʷəʔelə site.
- The existing Burnaby CMHA provides highly specialized tertiary care assessments, diagnostic, and treatment services to people with a complex mix of problematic substance use, mental illness, physical health, and behavioural and social problems. The continuum of services includes comprehensive, inter-disciplinary assessment, treatment, and therapeutic and rehabilitation activities.
- The new RFHC will increase bed capacity from 94 to 105 beds (11 beds) and was procured as a design-build project.[1]

Budget

| Funding Sources | Project Cost in ($ millions) | % of Project Cost |
|---|---|---|
| Ministry of Health | 131.4 | 100% |
| **Total Project Cost** | **$131.4** | **100%** |

The budget reflects settlement of a delay claim with EllisDon for treatment of artifact bearing soil (ABS) and soil contamination.

Schedule

| Milestone | Date |
|---|---|
| Government approval | October 2015 |
| *Announcement of New Centre for Mental Health and Addiction* | *November 17 2017* |
| Completion of planning and design | December 2017 |
| Start of procurement process | May2016 |
| Completion of procurement process | June 2017 |
| Completion of demolition of Unit A building | November 2017 |
| Start of ABS and contamination remediation | December 2017 |
| Completion of ABS and contamination remediation | April 2019 |
| Start of construction | April 2019 |
| *Announcement of naming as the Red Fish Healing Centre* | *June 19 2020* |
| Estimated completion of construction | June 2021 |
| Estimated opening for patients | October 2021 |

[1] The 88 beds at the Burnaby CMHA was to include a new 14-bed high intensity treatment unit. PHSA has been unable to secure a building permit from the City of Burnaby for the needed renovations for these beds. As a short-term alternative, 20 acute stabilization beds were operational on the Burnaby site on May 23, 2016. This brings the total number of beds in operation at the Burnaby site to 94. The high intensity beds will be incorporated into the replacement CMHA as planned.

# LEGISLATIVE SESSION - FACT SHEET

Background

- In 2013, the Province announced a vision consultation process on the future of the Riverview lands in Coquitlam and directed BC Housing to lead this process.
- In December 2015, after extensive consultation, *A Vision for Renewing Riverview Lands* was released. This document lays out a master development plan for a comprehensive mixed-use community that will include a health care district as well as market and supportive housing.
- BC Housing is the lead with respect to First Nation consultation process for the site as well as responsible for the redevelopment of the site.
- In October 2015, Treasury Board approved the Business Plan for the CMHA Replacement, now the RFHC Project.
- A PHSA Capital Project Board was established to provide oversight on PHSA major capital projects including the RFHC Project, with representation from BC Housing.
- The Ministry of Citizens' Services, negotiated lease extensions of the Burnaby CMHA facility to December 31, 2021, on behalf of PHSA.
- In May 2016, a Request for Qualifications (RFQ) was issued seeking qualified companies to design and build the RFHC. In October 2016, the Request for Proposal (RFP) was issued to the 3 shortlisted proponents, and in May 2017, EllisDon was selected as the preferred proponent.
- The site of the new RFHC has been identified as an area of archaeological interest and is protected under the *Heritage Conservation Act*. Alterations to archaeological sites may proceed under appropriate permits held by professional archaeologists under appropriate assessment guidelines and work plans. Work plans must meet regulatory standards as well as First Nation cultural heritage standards and best-practices.
- In December 2017 excavation was placed on hold while PHSA developed a plan to address ABS and soil contamination concerns.
- Delay claims related to site discoveries were dealt with on a contractual basis between PHSA and EllisDon. In October 2018, the EllisDon contract was amended to remove the transportation of ABS from the RFHC site. The PHSA acquired multiple contracts to do this work, including the Kwikwetlem First Nation Enterprises (KFNE).
- In Fall 2019, PHSA and EllisDon entered into negotiations to settle the claim delay related to the soil discoveries. Subsequently, Treasury Board approved the new project schedule and revised total capital cost in April 2020.
- On March 10, 2021, BC Housing in partnership with Kwikwetlem First Nation publicly announced a change in the Riverview site name to the site's ancestral name of səmiq̓ʷəʔelə (pronounced Suh-MEE-kwuh-EL-uh, meaning 'Place of the Great Blue Heron').

## FINANCIAL IMPLICATIONS

In April 2020, the government approved a revised total capital budget for the RFHC Project of $131.4 (inclusive of the project reserve).

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**Approved:**
March 12, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Richmond Hospital New Acute Care Facility

### TOPIC

Update on the proposed Richmond Hospital (RH) Redevelopment project (the Project).

### CURRENT SITUATION

Cabinet Confidences

- VCHA submitted a completed Business Plan to the Ministry in November 2020. The Business Plan is proceeding through the government review and approval process.

### KEY FACTS

- VCHA advises that the North Tower at RH urgently needs replacement, as it no longer meets the quality of care standards, building code or seismic standards, and is well beyond its useful life with a Facility Condition Index (FCI) of 0.80.
- In June 2016, plans to proceed with a Concept Plan in support of the potential development of a replacement patient care tower at RH were announced.
- In January 2017, VCHA submitted a Concept Plan to the Ministry for a new Acute Care Facility (ACF) at RH that is consistent with the High-Level Master Plan (HLMP) and proposed the following:
    - Replace 108 inpatient beds currently located in the RH North Tower and add 108 new inpatient beds for a total of 216 beds in the new ACF.
    - Address key issues within the perioperative area by accommodating perioperative services in the new ACF. This will include expansion of the operating rooms, surgical day care, post-anaesthetic recovery room, and the medical device reprocessing department.
- In February 2017, Richmond residents Dr. Tony Yurkovich and Nancy Yurkovich joined with more than 10 families and organizations to pledge a combined $25 million towards a new ACF. While they do not wish to disclose individual donation amounts, the total donation is the single largest gift in the history of the RH Foundation.
- In recognition of the Yurkovich's generosity, the North tower has been renamed the Yurkovich Family Pavilion. In the future, the name will transfer to the new ACTF
- After the Concept Plan was approved, VCHA reviewed the Project's assumptions and scope including the implications of the complex, multi-year phasing that would be required to complete the Project. This clinical review identified significant facility challenges related to complex phasing, poor patient and staff flows, negative patient experiences and potential increases in operating costs should VCHA proceed with the scope outlined in the original Concept Plan.
- In April 2020, Treasury Board approved an updated Concept Plan, which addresses service delivery capacity pressures for the RH emergency department and medical imaging, seismic and flood plain risks for critical departments, and flow issues across the campus, in addition to replacing and expanding inpatient beds and the perioperative suite. The Project scope will be confirmed as part of the business planning process.

Budget (Based on Approved Concept Plan Update – Not Publicly Disclosed)

Government Financial Information

| **Funding Sources** | |
|---|---|
| Ministry of Health | |
| VCHA | |
| Richmond Hospital Foundation | |
| **Total Project Cost** | |

# LEGISLATIVE SESSION - FACT SHEET

Government Financial Information

Background

- RH opened in 1964 (including the North Tower), with additions in 1980 (South Tower), and in 1997 (Westminster Tower). RH is a large community hospital serving the needs of residents in Richmond, Delta, as well as travelers using the Vancouver International Airport and BC Ferries. Services provided at RH include Emergency, Ambulatory Care, Diagnostics, Intensive Care and Coronary Care, Maternity, Psychiatry and Surgery.
- In 2013 the Richmond Community of Care HLMP was undertaken to produce an Integrated Service and Master Concept Plan that forecasts needs to 2030. The HLMP was completed in March 2015.
- In February 2014 a structural assessment of the North Tower was conducted, and the building was assigned a seismic rating of H1. This rating is defined as: most vulnerable structure; at highest risk of widespread damage or structural failure after an earthquake.
- The North Tower houses 108 of the 240 beds at RH, as well as the surgical suites, sterile processing, medical imaging, and the pharmacy.

## FINANCIAL IMPLICATIONS

Government Financial Information

- The updated project capital cost and funding sources will be confirmed as part of the Business Plan review and approval process.

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**Approved:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Stuart Lake Hospital Replacement

### TOPIC

Update on the Stuart Lake Hospital (SLH) Replacement in Fort St. James (the Project).

### CURRENT SITUATION

Cabinet Confidences

- The Design Early Works Agreement (DEWA) Request for Proposal (RFP) closed on October 22, 2020.
- The DEWA RFP evaluation completed in December 2020 and Graham Design Builders was selected as the preferred Proponent. An announcement regarding the preferred proponent will occur shortly.
- The Design Build Agreement RFP will be issued to Graham Design Builders Cabinet Confidences with the first Financial Submission due on Cabinet Confidences

Cabinet Confidences

### KEY FACTS

Scope

The approved Business Plan includes:

- A new 27-bed (9 acute care and 18 long-term care) facility that is expected to be 2-levels, including a partial basement to accommodate sloping terrain, with a gross building area of approximately 6,300 $m^2$, more than three times the size of the current facility (1,759 $m^2$);
- Private rooms, expanded emergency department, an increase in long term care beds from 6 to 18, and a primary care centre co-located with the hospital.

Budget

| Funding Sources | Project Costs ($ millions | % of Total Project Cost |
|---|---|---|
| Ministry of Health | 97.72 | 84% |
| Stuart Nechako RHD | 18.40 | 16% |
| **Total Project Cost** | **$116.12** | **100%** |

Schedule

| Milestone | Date |
|---|---|
| Concept Plan Approval | September 2018 |
| *Announcement of Concept Plan Approval* | *October 2018* |
| Business Plan Approval | January 2020 |
| *Announcement of Business Plan Approval* | *January 2020* |
| Issue RFQ | April 2020 |

Cabinet Confidences

Background

- The District of Fort St. James is located on the south-eastern shore of Stuart Lake, at the head of the Stuart River. Together with Vanderhoof (60 km to the south) and Fraser Lake (another 60 km to the west of Vanderhoof), Fort St. James is part of what is known locally as the "tri-cities of the Stuart Nechako." At 160 km away, Prince George is the closest large city.
- Fort St. James is a member of the Bulkley Nechako Regional District, and the Stuart Nechako Regional Hospital District (SNRHD).

- Originally constructed in 1972, and built with 21 hospital beds capacity, SLH now provides 24-hour, on-call emergency services and acute nursing services to Fort St. James and the surrounding area. Laboratory and diagnostic imaging services are available from 9:00 am–noon on weekdays, with remaining hours provided by on-call service.
- Many services are shared with and referred to the larger St. John Hospital in Vanderhoof.
- The existing SLH has 12 beds; 6 acute including 1 maternity beds, and 1 palliative care bed plus 6 long-term care beds.
- The SLH is in poor physical condition, and a 2012 review of the hospital indicated a deteriorated state of the hospital and related infrastructure systems.
- The poor layout and physical deterioration of SLH do not allow effective implementation of health care best practices in areas such as infection prevention, privacy, and accessibility.
- Discussions between NHA and the SNRHD regarding the replacement of SLH began in 2008.
- In early 2014, NHA issued an RFP for the Master Planning and Functional programming consulting services which included an in-depth facility assessment report.
- The Master Program and Plan review informed the SLH Concept Plan which was completed and submitted by NHA to the Ministry of Health in the fall of 2015; however, funding was not available.
- As part of Budget 2018, the Ministry of Finance (MoF) added notional capital funding for the replacement of SLH to the Ministry's Capital Plan. The Ministry requested the 2015 Concept Plan be updated and submitted by June 2018.
- On January 18, 2020, the Premier announced the approval of the Business Plan in Fort St. James.

Advice/Recommentations

- In March 2020, NHA completed an interim Primary Care project in Fort St. James that includes tenant improvements to an existing leased site Government Financial Information The scope of the SLH replacement project includes co-locating the primary care services at the hospital site.
- The RFP for the DEWA was released to three shortlisted proponents (Graham Design Build LP, Clark Builders, SBW Wright Construction) on August 4, 2020.

## FINANCIAL IMPLICATIONS

Government Financial Information

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**Approved by:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## University Hospital of Northern BC Redevelopment

### TOPIC

Update on the University Hospital of Northern BC (UHNBC) Redevelopment project (the Project).

### CURRENT SITUATION

- Treasury Board approved the Concept Plan for the Project on July 16, 2020.
- On September 20, 2020, the Minister of Health announced approval of the UHNBC Redevelopment Concept Plan and that the business planning phase will now get underway.
- The business planning phase, including Treasury Board approval, is estimated to take approximately 15 – 18 months to complete, and is on target to be submitted to the Ministry of Health in March 2022.
- On January 15, 2021, the Project's facility consultant team was awarded to DIALOG BC Architecture Engineering Interior Design Planning, Inc.
- The Requests for Proposals (RFP) for equipment consultants will be issued at the end of January 2021.

### KEY FACTS

Scope

The approved Concept Plan includes:

Government Financial Information

Budget

Government Financial Information

Schedule

| Milestone | Date |
|---|---|
| Concept Plan Approval | July 2020 |
| *Announcement of Concept Plan Approval* | *September 2020* |

Cabinet Confidences

Background

- UHNBC is located in the City of Prince George in the eastern portion of the Northern Interior Health Services Delivery Area (NIHSDA), and is the largest acute care facility within the Northern Health Authority (NHA).
- UHNBC originally opened in 1958, the west wing was added in 1978, and the east wing in 2003.

- The facility has 55,399 $m^2$ of total space and is a community hospital for approximately 100,000 Prince George and catchment area residents.
- It is also a regional hospital providing specialized health services for NHA to close to 300,000 people over an area of approximately 600,000 $km^2$.
- UHNBC also functions as a teaching hospital that supports the Northern Medical Program, a joint medical program by the UBC Faculty of Medicine and UHNBC for training of physicians in BC.
- In late 2014, the NHA Board identified the need to look at the UHNBC Hospital model to consider future capacity issues, services offered and changes in demographics.
- The population of NHA is expected to grow 8% between 2017 and 2032, and the proportion of people aged 75 and above is expected to grow by 105% by 2032.
- In November 2016, a Master Program and Master Plan for the redevelopment of UHNBC was presented to the NHA Board.
- In March 2017, the NHA developed a proposal for the Project to construct a new building to include perioperative, mental health and cardiac services.
- On April 7, 2017, it was announced that NHA would be developing a Concept Plan based on its proposal.
- On December 15, 2017, NHA completed the Concept Plan and submitted it to the Ministry for consideration.

Government Financial Information

- NHA has completed two additional projects to address urgent needs at the site:
  - Expanding inpatient bed capacity ($8 million) – Adding 24 additional medical inpatient beds. The unit opened in May 2019.
  - Electrical system upgrades ($4.5 million) – Upgrades to the electrical system to improve reliability and prevent power outages. That project completed February 2019.

## FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**
March 8, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Vancouver Coastal Health Authority

### TOPIC

The Vancouver Coastal Health Authority (VCHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the VCHA via the annual Regional Services funding allocation.

### CURRENT SITUATION

VCHA had a surplus of $7.378 million in its 2019/20 Audited Financial Statements excluding affiliates, creating a surplus of $9.971 million with Providence Health Care (PHC) and Louis Brier Hospital included.

### KEY FACTS

- This Ministry's Regional Services funding represents the vast majority of the VCHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, preferred accommodation, etc.).
- Working in co-operation with the VCHA to provide health services within the VCHA region are 2 denominational affiliates or hospital societies established per the Hospital Act, namely PHC and Louis Brier Hospital in Vancouver. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements (2 former denominational affiliates or hospital societies, R. W. Large Memorial Hospital in Bella Bella and Bella Coola General Hospital were absorbed by VCHA as of April 1, 2014).
- The Ministry does not provide Regional Services operating funding directly to the denominational affiliates; the VCHA is responsible for allocating operating funding to its denominational affiliates. The financial results of the VCHA and the denominational affiliates are consolidated in the Government Reporting Entity.

### FINANCIAL IMPLICATIONS

2019/20 Audited Financial Statements of VCHA (excluding PHC and Louis Brier)

| | |
|---|---|
| Total Revenues | $4,022.797 million |
| Total Expenses | $4,015.419 million |
| Surplus (Deficit) | $7.378 million |

2019/20 Breakdown of Total Revenues by Major Funding Source
Year ended March 31, 2020
($ Millions)

| | Budget | 2020 | 2019 |
|---|---|---|---|
| **Revenues** | | | |
| Ministry of Health Contributions | 3,004.003 | 3,081.482 | 2,847.509 |
| Medical Services Plan | 253.630 | 280.764 | 254.647 |
| Recoveries from other health authorities and BC government reporting entities | 144.547 | 184.767 | 157.210 |
| Other contributions | 170.736 | 178.764 | 177.355 |
| Patients, clients and residents | 120.018 | 145.887 | 131.641 |
| Amortization of deferred capital contributions | 85.378 | 88.520 | 79.449 |
| Other revenues | 29.803 | 40.658 | 40.472 |
| Research and designated revenue | 20.000 | 18.007 | 18.188 |
| Investment income | 2.160 | 3.948 | 3.568 |
| | 3,830.275 | 4,022.797 | 3,710.039 |

Note: Amounts as per 2019/20 audited financial statements.

# LEGISLATIVE SESSION - FACT SHEET

Regional Services Funding Allocation (to VCHA from Ministry)

2017/18 - $2.742 billion (per 2017/18 Final Funding Letter)
2018/19 - $2.842 billion (per 2018/19 Final Funding Letter)
2019/20 - $3.075 billion (per 2019/20 Final Funding Letter)

Government Financial Information

Estimated Full-Time Equivalents (FTEs)

According to Health Sector Compensation Information System 2018 Quarter 4 data, the estimated number of FTEs – including PHC, but excluding other denominational affiliates and contracted agencies – is as follows:

Union – 17,986
Non-Union/Management – 1,965

Government Financial Information

VCHA Population

- According to BC Stats, VCHA's population forecast and rate of growth is as follows:
    - 2020/21 – 1.225 million, 1.17% growth
    - 2021/22 – 1.241 million, 1.31% growth
    - 2022/23 – 1.258 million, 1.40% growth
- As of November, 2020, approximately 17.75% of VCHA's population is age 65 and over.

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**Approved:**
May11, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Vancouver Island Health Authority

### TOPIC

The Vancouver Island Health Authority (VIHA) is 1 of 6 health authorities created in 2001. The Ministry of Health provides annual operating funding directly to the VIHA via the annual Regional Services funding allocation.

### CURRENT SITUATION

VIHA had a surplus of $0.489 million in its 2019/20 Audited Financial Statements excluding affiliates, creating a surplus of $0.034 million with Mount St. Mary Hospital.

### KEY FACTS

- This Ministry's Regional Services funding represents the vast majority of the VIHA's annual operating revenues. Other significant sources of operating revenues include funding from the Medical Services Plan, the Provincial Health Services Authority, and fees paid by patients and other health insurers (e.g., fees for services provided to non-residents of Canada, parking, and preferred accommodation).
- Working in cooperation with the VIHA to provide health services within the VIHA region are 2 denominational affiliates or hospital societies established per the *Hospital Act*, namely Mount St. Mary Hospital in Victoria and St. Joseph's General Hospital in Comox. These denominational affiliates are separate legal entities, and each has its own board of directors and issues its own audited financial statements.
- St. Joseph's General Hospital transferred its acute care services to the VIHA on October 1, 2017, through the North Island Hospital, Comox Valley, Courtenay. St. Joseph's General Hospital continues to operate 117 residential care beds and 4 hospice beds at its Comox site. St. Joseph's General Hospital reached an agreement with Providence Residential and Community Care Services Society (PRCC) to transfer ownership and operation of St. Joseph's General Hospital to PRCC effective April 1, 2019, at which time was superseded by PRCC as an affiliate of the VIHA.
- The Ministry does not provide Regional Services operating funding directly to the denominational affiliates; the VIHA is responsible for allocating operating funding to its denominational affiliates. The financial results of the VIHA and the denominational affiliates are consolidated in the Government Reporting Entity.

### FINANCIAL IMPLICATIONS

2019/20 Audited Financial Statements of VIHA (Excluding Mount St. Mary Hospital)

| | |
|---|---|
| Total Revenues | $2,770.771 million |
| Total Expenses | $2,770.282 million |
| Surplus (deficit) | $0.489 million |

2019/20 Breakdown of Total Revenues By Major Funding Source
Year Ended March 31, 2020
($ Millions)

| | Budget | 2020 | 2019 |
|---|---|---|---|
| **Revenues** | | | |
| Ministry of Health Contributions | 2,171.848 | 2,238.099 | 2,047.321 |
| Medical Services Plan | 180.271 | 183.345 | 175.823 |
| Recoveries from other health authorities and BC government reporting entities | 121.774 | 135.076 | 125.362 |
| Amortization of deferred capital contributions | 87.904 | 85.059 | 84.814 |
| Patients, clients and residents | 65.515 | 72.562 | 66.584 |
| Other | 40.806 | 50.297 | 43.331 |
| Other contributions | 5.941 | 4.983 | 4.872 |
| Investment income | 1.536 | 1.350 | 1.588 |
| | 2,675.595 | 2,770.771 | 2,549.695 |

Note: Amounts as per 2019/20audited financial statements.

# LEGISLATIVE SESSION - FACT SHEET

Regional Services Funding Allocation (to VIHA from Ministry)

2017/18 - $1.956 billion (per 2017/18 Final Funding Letter)
2018/19 - $2.048 billion (per 2018/19 Final Funding Letter)
2019/20 - $2.256 billion (per 2019/20 Final Funding Letter)

Government Financial Information

Estimated Full-Time Equivalents (FTEs)

According to Health Sector Compensation Information System 2018 Quarter 4 data, the estimated number of FTEs – excluding Mount St. Mary Hospital, St. Joseph's General Hospital and other contracted agencies – is as follows:

Union – 13,006
Non-Union/Management – 1,416

Government Financial Information

VIHA Population

- According to BC Stats, VIHA's population forecast and rate of growth is as follows:
  2020/21 – 0.875 million, 0.83% growth
  2021/22 – 0.883 million, 0.95% growth
  2022/23 – 0.892 million, 1.03% growth
- As of November, 2020, approximately 24.7% of VIHA's population is age 65 and over.

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**Approved:**
June 3, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

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| 42. | Tahltan Nation |
| 43. | Wandering and Silver Alert |

# LEGISLATIVE SESSION - FACT SHEET

## 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 Policy Manual (HCC) 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.

### CURRENT SITUATION

LTC Access Policy

- The Ministry 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 2020/21[1]:
  - In BC, clients admitted to LTC from acute care waited, on average, 30 days if their wait started in hospital, and 90 days if their wait started in community prior to acute care admission.
  - Clients admitted to LTC directly from community waited, on average, 4 months (120 days).
  - When looking at both admissions from community and from acute in Q3, 41% of clients were admitted directly to a Preferred Care Home (PCH). Broken down, 30% of LTC admissions from acute care were to a PCH and 52% of LTC admissions from community were to a PCH. At the provincial level, admissions directly to a PCH has remained relatively consistent (average of 43%, ranging between 41%-46%) over the last 5 quarters and since the policy was implemented.
  - Clients admitted to an Interim Care Home (ICH) and transferred to a PCH in Q3 waited an average of 6 months (178 days) for transfer to a PCH. This is an 18% decrease from the previous quarter and aligns with easing of the COVID-19 emergency response measure which suspended transfers between care homes, including transfers from an ICH to a PCH.
  - Initial concerns that the average provincial length of stay (LOS) of alternative level of care (ALC) clients in acute would be negatively impacted by the policy change have not materialized (based on the most recent hospital data for Q2 2020/21).
    - The Q2 2020/21 provincial proportion of ALC client discharged into LTC was 21% (1,017 clients).
    - The average LOS increased slightly during the implementation phase of the new LTC access policy with the most recent quarter (average LOS of 30 days) remaining below the Q1 2019/20 average (average LOS of 39 days).
- Recent fluctuations in average LOS for ALC clients discharged into LTC align with the COVID-19 emergency response measures implemented to support acute care capacity It should be noted data from 2020/21 is not directly comparable to 2019/20 data due to the impact of COVID-19 and the various policy adjustments, restrictions and suspensions implemented throughout the year to mitigate the risk of transmission in LTC homes and support acute care capacity.
- Q4 data will be available at the end of June 2021.

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 and an e-learning course.

[1] Ministry of Health. Long-Term Care Access Monitoring Indicators Summary Report (2020/21 Q3).

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

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 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:
        - the expectation is 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 be 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.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

May 7, 2021 – Teri Collins, ADM, Health Services Division

May 26, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

# LEGISLATIVE SESSION - FACT SHEET

## Assisted Living – Mental Health and Substance Use

### TOPIC

The government is committed to promoting health and safety for vulnerable adults receiving assisted living services under the *Community Care and Assisted Living Act* (CCALA). Mental health and supportive recovery residences are two types of assisted living that are regulated by the CCALA.

### CURRENT SITUATION

- New Assisted Living Regulations and amendments to the *Community Care and Assisted Living Act* (CCALA) came into force December 1, 2019.
- The amendments enhance the Assisted Living Registry's inspection and enforcement powers, such as authorizing monitoring inspections, and enabling the attachment of conditions upon registration.
- The new regulatory requirements also bring increased health and safety protections for residents which operators are must comply with. These include new reportable incident reporting criteria, increased staff training requirements and policies and procedures.
- Over the winter of 2019 the Registry delivered phase 1 of the legislative changes, which included education sessions to operators, comprehensive resources for operators and the public, and a new website.
- Phase 2 of the legislative changes planned to deliver an online eLearning resource, additional education sessions for operators and education sessions for health authorities. Phase 2 also included implementing policies and procedures within the Registry program to conduct monitoring inspections, however, this work was stalled due to COVID 19.
- COVID 19 non-essential travel requirements impacted the Registry's ability to carry out site visits for routine monitoring inspections.
- The Registry continued to conduct telephone investigations as well as site visits when the situation posed an increase risk to the health and safety of the persons at a registered residence or an alleged unlawful residence.
- In 2020, 36 new assisted living residence applications were received. 22 of these were for supportive recovery and 14 were for mental health.
- The Registry requires mandatory incident reports to be submitted, by the operator, within 24 hours of the incident occurrence. Operators must report on specific incident types as stated in the Assisted Living Regulation, such as overdose, police calls, missing/wandering residents, and disease outbreak.
- 283 incident reports were received which required Registry staff to review and follow up with the operator. Some incident reports required multiple follow ups and further assessment for compliance with the legislation to ensure the health and safety of the residents.

### KEY FACTS

- Assisted living is housing which provides one or more assisted living services (i.e. assistance with medication management, assistance with safekeeping money and personal property, assistance with behaviour management, and psychosocial supports) and five hospitality services (meals, housekeeping, laundry, recreation, emergency response system).
- Mental Health residences typically provide behaviour management as the main assisted living service, which includes supporting a resident to reduce and manage occurrences of behaviours that negatively affect the resident's health, safety, or quality of life. This support is done in consultation with appropriate health professionals and is based on an individualized personal service plan.
- Supportive Recovery residences typically provide Psychosocial Supports and Distributing Medication as the main assisted living services.
- Anyone who provides support and services to 3 or more adults who are not related by blood or marriage to the operator of the premises requires a registration. The ALR program must assess operations to determine if a registration is required as defined in the CCALA. This work may require

ALR staff to conduct site visits jointly with municipal bylaw and/ or local RCMP, particularity in the city of Surrey.

- The ALR is also responsible for monitoring an operator's compliance with the CCALA and regulation as well as investigating complaints and reportable incidents relating to the health and safety of the persons living at the residence.
- Since September 2012, high-level information from substantiated complaints has been posted on the Ministry of Health's Assisted Living Registry website. As of September 1, 2018, the Assisted Living Registry has also posted information regarding assisted living residences operating without a valid registration.
- There are currently 119 support recovery residences and 27 registered mental health assisted living residences.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
March 8, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
May 3, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Assisted Living – Seniors

### TOPIC

*Community Care and Assisted Living Act* (CCALA) Bill 16 and the new Assisted Living Regulation was brought into force on December 1, 2019 to increase flexibility for the assisted living sector to enable operators to provide a broader range of services, and to improve the regulatory oversight for all assisted living residences.

### CURRENT SITUATION

- New Assisted Living Regulations and amendments to the CCALA came into force December 1, 2019.
- Over the winter of 2019 the Assisted Living Registry delivered phase 1 of the legislative changes, which included education sessions to operators, comprehensive resources for operators and the public, and a new website.
- Phase 2 of the legislative changes planned to deliver an online eLearning resource, additional education sessions for operators and education sessions for health authorities. Phase 2 also included implementing policies and procedures within the Registry program to conduct monitoring inspections, however, this work was stalled due to COVID 19.
- The new regulatory provisions include registration requirements as well as standards for operation, including housing, employees, emergency preparedness, residents, general health and safety, hospitality services, assisted living services, and administrative matters.

<u>New Registrations, De-registrations, and Renewals</u>

- As of Mar 31February 24, fiscal year 2020/21, four applications to open new seniors assisted living residences were approved. The registration process takes between three and six months on average for completion of required components (such as municipal business licence) and final investigator review and registration.
- As of Mar 31 February 24, fiscal year 2020/21 the Registry de-registered 12 residences as a result of operators changing their business model or choosing to stop operating.
- As of Mar 31February 24, fiscal year 2020/21 the Registry renewed 213 seniors' residences. Renewal is an annual requirement under the *Community Care and Assisted Living Act*CCALA to hold a valid assisted living registration. 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.

<u>Incident Reports</u>

- 32521,240 incident reports were received, reviewed and are now closed.
- The Registry requires mandatory incident reports to be submitted, by the operator, within 24 hours of an incident occurrence. Operators must report on specific incident types as stated in the Assisted Living Regulation, such as missing/wandering residents, falls and disease outbreak.
- All incident reports are reviewed by a Registry investigator, logged and data entered in to the Registry database. An investigator reviews each incident to determine if the operator responded to the incident appropriately, if the operator could have prevented the incident from occurring and what steps the operator is taking to prevent such incidents from occurring again. Incident reports regularly require multiple follow ups and further assessment for compliance with the legislation to ensure the health and safety of the residents.

<u>COVID Protocol</u>

- COVID-19 non-essential travel requirements impacted the Registry's limited site visits for routine monitoring inspections.
- The Registry continues to conduct telephone investigations as well as site visits when the situation poses an increased risk to the health and safety of the persons at a registered residence or an alleged unlawful residence.

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

- The CCALA, which came into force in 2004, established an Assisted Living Registrar to oversee registration and respond to concerns about health and safety in assisted living residences.
- In January 2012, the registry operations were moved into the Ministry of Health to ensure alignment of the Registrar's work. The Assistant Deputy Minister of the Health Services Division was appointed as the Assisted Living Registrar (ALR) in December 2018.
- The ALR 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. Anyone with a concern can make a complaint to the Registry. Registry staff conduct investigations that are remedial in nature.
- In 2016, government amended the CCALA to increase flexibility and allow more than two prescribed services to be provided in assisted living. This change was made in response to recommendations by the Seniors Advocate and other stakeholder groups, who believed people who could still live safely in assisted living were being moved into residential care prematurely.
- The amendments to the CCALA also included enhancements to the ALR's inspection and enforcement powers, such as authorizing monitoring inspections, and enabling the attachment of conditions upon registration. The ALR is currently implementing policies and procedures within the program to conduct monitoring inspections.
- Assisted living is housing which supports adults who require support but can make decisions on their own behalf that are necessary to live safely in a semi-independent environment.
- Assisted Living residences provide 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).
- Residences which meet the definition of assisted living are required to be registered with the provincial Assisted Living Registry, regardless of whether they are publicly subsidized or private pay.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
May 3, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Availability of Sexual Assault Forensic Examinations (Rape/Sexual Assault Kits)

### TOPIC

- A Sexual Assault Forensic Examination (SAFE) is a set of medical-legal processes that include the collection of biological material, recordings of relevant patient history, and/or documentation of any injuries.
- SAFE services can be accessed throughout the province; where services are not directly available at a local facility, they can be accessed through transport and/or alternate pathways.

### CURRENT SITUATION

- Sexual assault (SA) survivors can receive medical care at all BC acute care hospitals and urgent care centres.
- SAFE is one element of SA care and the overarching issue of Gender Based Violence (GBV) (see Gender Based Violence and Sexual Assault during COVID-19 Fact Sheet).
- SAFE services are available in all health authorities in BC.
- Where SAFE services are not directly available at a local facility, they may be accessed through transport and/or alternative pathways. (see Access to SAFE section).
- A SAFE Working Group, including broad cross-government and health authority representation, is developing a provincial SAFE policy to reduce variability in local and regional program approach, delivery and training through a defined service delivery model.

### KEY FACTS

SAFE Services

- Timely access to evidence-informed, high-quality, survivor-centred SAFE services is important for SA survivors; at the patient's request, SAFE samples and examination results can be used as evidence to support the investigation and prosecution of crimes.
- Samples collected during SAFE provision and examiner testimony can be critical to the successful prosecution of those who perpetrate the crime of SA.
- Samples collected during SAFE provision are valid and effective even when collected several days following a SA. Testimony and patient history are not as time sensitive as physical evidence collection. Although the sooner the better, victims are always encouraged to seek care if or when they choose.

Access to SAFE

- SAFE services are best performed by trained and competent staff to ensure collected samples and examiner testimony is admissible in legal proceedings. Since SAFE does not have to be performed immediately after a SA, there is time for victims to receive SAFE at a properly equipped facility with trained and competent examiners.
- Determining factors for the availability of SAFE services in hospitals and urgent care centres can include:
    - The need for SAFE to be performed by specially trained medical professionals -- Specialized SAFE training provides examiners with an understanding of how to perform SAFE in a survivor-centred manner, properly prepare and store samples, and provide testimony in criminal proceedings;
    - Ability to maintenance a level of competence related to provision of SAFE -- Some geographic areas may experience requests for SAFE at a lower volume making it a challenge to maintain necessary skill sets; and
    - Availability of necessary equipment and physical space.
- In communities where SAFE is not provided, services may be accessed by:
    - Transporting the patient to the nearest community that offers SAFE;
    - A mobile SAFE team travels to the patient to provide care; or
    - The on-site care provider connecting with a sexual assault service specialist through the Rapid Access to Consultative Expertise (RACE) for real time telephone advice.

Current Initiatives on SAFE

- The SAFE Working Group is comprised of representatives from the Ministry of Health, each health authority including the Provincial Health Services Authority and the First Nations Health Authority, and the Ministry of Public Safety & Solicitor General (PSSG), the Ministry of Finance, Gender Equity Office (GEO) and a SAFE expert.
- Current work to improve both the accessibility and quality of SAFE services in BC is focused on the following areas:
    - Public policy advice that is informed by cultural safety and humility, trauma-informed practice and gender equity;
    - Survey of current locations and practices on the provision of SAFE in Emergency Departments and Urgent and Primary Care Centres (see Table 1 below);
    - Improving pathways of access for SAFE in rural and remote areas and communities that experience a low incidence of individuals presenting at emergency departments after a SA;
    - Achieving appropriate levels of education, training and competency across medical professionals that perform SAFE;
    - Access to equipment, training and other resources necessary to provide high quality SAFE services and store collected evidence.

**Table 1:** Preliminary Survey data: *SAFE Sites Environmental Scan 2020*

| Health Authority | Number of sites indicating direct provision of SAFE services |
|---|---|
| Interior Health Authority | 7 |
| Fraser Health Authority | 2 |
| Vancouver Coastal Health Authority | 5 |
| Island Health Authority | 9 |
| Northern Health Authority | 6 |
| Provincial Health Services Authority | 1 |

- The Ministry continues to work with health authorities to develop and implement province-wide strategies to ensure best practices are followed when treating SA survivors under the age of 18. This includes best practices around accessibility, training, evidence collection and chain of custody at all facilities that offer SAFE services, and reporting duties at all health care facilities.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
February 22, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

# BC Emergency Health Services – Independent Review

## TOPIC

An independent review was completed in 2019 on the case of a woman who died after paramedics were unable to reach her for 35 minutes due to building access issues.

## CURRENT SITUATION

The Ministry of Health (MoH) and BC Emergency Health Services (BCEHS) are working collaboratively to address 8 of the 14 recommendations from the *External Review of a Death during Prehospital Care* report that are not yet complete..

| # | Recommendation in Progress | Status |
|---|---|---|
| 1 | BCEHS dispatchers should always have easy and obvious access to important information related to the scene. Policy and procedures should be developed to routinely and effectively share and access information in real time known to police, fire and ambulance dispatch centers or paramedic and first responder crews. | BCEHS is working with first responders to ensure that all the first responders on live calls can share vital information in real time. BCEHS has met with key Fire Chiefs to identify the data points that would be beneficial to both parties and recommendations have now been taken to the Regional Administrative Advisory Committee to collaboratively develop a generic data sharing agreement that can be used across the province. A data sharing trial starting with ECOMM dispatch centre was expected to go live with a BCEHS CAD upgrade.<br>Completion date: The CAD upgrade has been postponed due to COVID-19 until September 2021 and plans to move ahead with the trial will follow shortly after. |
| 3 | The status of allied emergency services responding to medical calls should be relayed to the BCEHS dispatcher who requested the response to ensure that it is appropriate for the patient condition. | |
| 8 | Each responding agency should be aware of the location and expected arrival of the other agency's units. Real time sharing of dispatch information should be facilitated either through computer aided-dispatch (CAD) to CAD interface, verbally or by other appropriate means. | |
| 2 | All responding emergency services should have clear and robust processes to gain rapid access to a multi-unit building. Building codes should be reviewed and revised to enable such rapid access when necessary. | This work is delayed. MoH will consult with the Office of Housing and Construction Standards. |
| 10 | A linked data system should be developed that allows reliable and valid analysis of patient cohorts that includes the Medical Priority Dispatch System (MPDS) determinant code, CRM recommendation, and patient outcome. | BCEHS has implemented data linkages within PHSA and with health authorities, including Medical Priority Dispatch System determinant and Clinical Response Model (CRM) recommendation for patient cohorts such as cardiac arrest, including serious heart attacks, and major trauma. A stroke patient cohort is under consideration.<br>BCEHS will continue to enhance existing Information Sharing Agreements and is exploring further data linkages. |
| 13 | Autopsies in sudden unexpected death are an essential component of a Learning Health System. They are important to understand how care can be improved in the future, through system changes or education. The Minister of Health should consult with the Solicitor General on how to ensure that the mandate for autopsies include this important health system learning function. | MoH sent a letter to the Ministry of Public Safety & Solicitor General (PSSG) in Feb 2020 requesting they consider this recommendation as the *Coroners Act* is within their jurisdiction. A response from PSSG is pending. |

## KEY FACTS

- BCEHS conducted an internal Quality Review of the incident under Section 51 of the *Evidence Act*. Sharing of information generated through Quality Reviews conducted under Section 51 is legally restricted. Review details are not made public and disclosure to other groups or individuals (including MoH) is extremely limited.

- The daughter of the deceased believed that the May 2018 implementation of BCEHS's CRM was to blame and expressed concern about the BCEHS Quality Review. The Minister of Health directed a subsequent independent review of the incident.
- The Minister of Health and BCEHS accepted all 14 report recommendations. These focus on improving communication among allied emergency services, ensuring appropriate and timely building access, ensuring appropriate patient/call urgency and equipment is in place and increasing engagement in emergency health system and critical patient safety event reviews.

911 Call Details

- On November 8, 2018, BCEHS received a 911 medical emergency call from a multi-unit building in Vancouver. The female patient was at first coherent but anxious as she described severe bleeding.
- Paramedics arrived at the building within five minutes but were initially unable to gain access through the front door and were then unable to access the resident's floor without a security fob.
- Paramedics asked dispatch to request firefighter building access assistance.
- Fire first responders were notified that a routine response was needed. This was based on incorrect information that a fire crew was in the fire hall very close by.
- Crews arrived at the patient's side 35 minutes after the initial call. The patient was pulseless and resuscitation attempts were unsuccessful.

Background on Independent Review

- The Minister of Health appointed two emergency physicians to complete the Independent Review. A redacted version of the resulting report was released publicly in September 2019.[1]
- The report summarizes details of the incident and describes complexities of delivering pre-hospital patient care, including collaboration among paramedics and other allied emergency services.
- The report describes emergency medical service call triage and resource-assignment processes, and notes potential for negative patient outcomes and system utilization when calls are incorrectly triaged, or resources are inappropriately dispatched (i.e. under or over responding).
- The report does not make any specific conclusions regarding the patient's death or the CRM but notes that the death may have been avoidable had paramedics been able to access the patient more promptly.

Background on BCEHS Clinical Response Model

- In May 2018, BCEHS updated the way it assigns paramedics, ambulances and other resources by implementing the CRM. Patient condition is first categorized by a Medical Priority Dispatch System and then resources are assigned using the CRM based on six categories (previously three).
- The CRM aims to get paramedics to the most critically ill and injured patients as quickly as possible while also improving the care experience of all patients.
- There has been criticism (including media reports) that implementation of the CRM resulted in decreased calls to fire departments. This is of particular concern in rural areas where an ambulance may not be immediately accessible due to resource availability and/or travel time.
- BCEHS data suggests that response times to critical calls have improved in most communities since the CRM was introduced.
- Fire departments are still called to high acuity calls such as cardiac arrest or suspected overdose and any calls related to fire, drowning, motor vehicle crashes or hazmat situations.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division

[1] https://www2.gov.bc.ca/assets/gov/health/conducting-health-research/bcehs-case-review.pdf

# LEGISLATIVE SESSION - FACT SHEET

## BC Emergency Health Services

### TOPIC

BC Emergency Health Services (BCEHS), part of the Provincial Health Services Authority, has worked to better integrate with the health system and ensure services are delivered with optimal patient care in mind.

### CURRENT SITUATION

- BCEHS responded to fewer pre-hospital events in 2020 (524,870) than in 2019 (530,801). This is likely related to people staying home due to COVID-19 and fewer motor vehicles on the roads.
- Some slower response times in 2020 compared to 2019 are likely related to the additional PPE requirements that paramedics are dealing with due to COVID-19.
- As part of the Rural, Remote, First Nations, and Indigenous Communities COVID-19 Response Framework, 55 new ambulances and 5 new aircraft have been deployed to support patient transfers. A longer-term strategy is being developed to best utilize these resources.

### KEY FACTS

- BCEHS provides provincial ambulance and emergency health services under the *Emergency Health Services Act*. BCEHS is also responsible for the planning and coordination of inter-facility patient transfers that require paramedic care and the community paramedicine (CP) program.
- Close to 5,000 BCEHS employees support patient care, including paramedics, medical emergency call-takers and dispatchers, nurses, front-line staff, administrators and managers.
- BCEHS operates three integrated Dispatch Operations Centres in Vancouver, Victoria and Kamloops. The three centres receive between 1,400 and 1,700 requests for emergency response each day.
- The three centres work closely with the BC Patient Transfer Services to coordinate more than 81,500 inter-facility patient transfers each year throughout British Columbia.
- To improve response times and better manage increased call volumes, BCEHS implemented (2017-2020) the Clinical Response Model (CRM), secondary triage, additional staffing resources, CP and e-patient records.

Dispatch and Response Times

- BCEHS prioritizes ambulance calls based on the information received from the 9-1-1 caller, and an internationally recognized system known as the Medical Priority Dispatch System (MPDS). MPDS is used by over 3,000 emergency medical services organizations. Patients with life-threatening symptoms including cardiac arrest, chest pain, breathing difficulties, and severe bleeding or unconsciousness generally receive a lights and sirens ambulance response.
- In May 2018, BCEHS introduced the CRM to guide dispatch in assigning resources to a call. Based on the patient condition and MPDS code generated, the call is assigned a colour: Purple (immediately life-threatening), Red (life threatening, urgent), Orange (urgent/potentially serious), Yellow (non-urgent), Green (possibly treat at scene) or Blue (further clinical telephone triage/advice). The aim is to get to the most serious, time-critical calls (Purple and Red) faster and to better match resources to patient with non-urgent conditions. BCEHS notifies fire first responders (FFR) agencies (who have agreements in place) of all extremely time critical calls as well as those requiring specific FFR skill set and calls with an expected arrival time of more than 10 minutes. Some communities continue to express concern over the CRM. Work is underway in collaboration with fire first responders to address concerns and in response to the OAG report.
- Post CRM implementation, BCEHS has seen a reduction in response times, despite >10,000 additional calls annually for the most serious calls (purple).

**Median Response Time by CRM Colour - Pre CRM (2017) and Post CRM (2020)**

| Community Type | Purple | | Red | | Orange | | Yellow | |
|---|---|---|---|---|---|---|---|---|
| | Pre CRM | Post CRM | Pre CRM | Post CRM | Pre CRM | Post CRM | Pre CRM | Post CRM |
| Metro / Urban | 07:43 | 07:20 | 09:01 | 09:08 | 10:36 | 11:12 | 15:28 | 17:01 |
| Rural | 08:43 | 07:53 | 09:00 | 08:59 | 09:12 | 09:27 | 10:41 | 11:16 |
| Remote | 17:19 | 17:09 | 19:35 | 19:14 | 20:03 | 20:02 | 23:22 | 24:06 |

**Pre-Hospital (MPDS) Event Volume by CRM Colour***

| Event CRM Colour | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| Purple | 12,239 | 9,859 | 8,447 | 12,034 |
| Red | 108,821 | 116,545 | 126,276 | 116,980 |
| Orange | 145,218 | 146,527 | 155,466 | 155,822 |
| Yellow | 245,478 | 242,928 | 236,957 | 236,776 |
| Total** | 511,756 | 515,859 | 527,146 | 521,612 |

**The increase in purple calls for 2020 is due to a code change. **Not including Green/Blue.*

- Almost half of 9-1-1 calls are triaged as non-urgent medical concerns. A secondary triage function allows BCEHS to offer care alternatives for patients and avoid unnecessary transport to hospital.
- The CliniCall team is comprised of Advanced Care Paramedic Specialists and Registered Nurses who conduct detailed clinical assessments using structured decision support tools which determines either an increased priority of ambulance response.

Community Paramedicine (CP)

- CP is intended to help reduce 9-1-1 calls, stabilize paramedic staffing in rural and remote communities, and bridge health service delivery gaps identified in collaboration with local health care teams. Qualified community paramedics (CPs) provide primary care, prevention and health promotion in partnership with local health care providers, in patients' homes or the community.
- The final phase of the CP program was implemented in 2019. 80 full-time equivalent CP positions were established in 99 rural and remote communities (attached). An analysis of the CP impact on 9-1-1 calls from nine communities found that proactive CP intervention reduced the number of calls by 39%.[1]
- In-person CP home visits were suspended in March 2020 due to COVID-19. Virtual patient visits were rapidly introduced, and high volumes of new patient referrals were received. Between March and December, 2020, CPs delivered 19,890 virtual visits with their patients. In June 2020, face-to-face patient visits were restarted for at-risk patients who cannot be served adequately through virtual care. Home health monitoring continues to be a part of the CP virtual health suite of services, with 409 enrollments to date and 166 currently active patients in communities receiving this service. A new COVID-19 Screening Assessment was introduced to support existing chronic disease patients identified as at risk of exposure to the virus.
- BCEHS completed a CP Telehealth Project, where paramedics visited patient's homes to facilitate a total of 50 telehealth visits with family physicians, to increase access to primary care for patients who normally have limited access. Evaluation showed success of the project and plans to expand to additional communities were underway in early 2020. This telehealth service has been put on hold during the COVID-19 pandemic.
- CP participation in COVID testing was a public health order Nov 16, 2020 and consultation with health authorities identified a need support at testing centres. Education and practice guidelines rolled out to CPs in December and was immediately followed by support in COVID testing centres where requested.
- In 2018, BCEHS created a new role for Advanced Care Paramedics (ACPs) in rural communities. The role builds on the CP program and introduced six rural advanced care community paramedics (RACCPs) with a broader clinical scope and expertise than Primary Care Paramedics trained as CPs.
- RACCPs have been working in Campbell River, Salt Spring Island, and Cranbrook since Fall 2018, and in Prince Rupert since Spring 2020. BCEHS is still trying to recruit RACCPs in Valemount and Fort St.
- BCEHS partnered with the University of Northern BC to evaluate the RACCP role. The phase one review of the project by UNBC found that the RACCPs are bridging gaps in care, but that more work was required to ensure clarity of roles and consistent policy and processes. UNBC will be doing a phase two examination of the integration of the RACCP role in March-December 2021 with the findings expected by March 2022.

## FINANCIAL IMPLICATIONS

N/A

**Approved:**
February 17, 2021 – Teri Collins, ADM, Health Services Division

[1] http://www.bcehs.ca/about-site/Documents/BCEHS%20Action%20Plan%20Year%202%20Progress%20Report%20final.pdf. Accessed January 20th, 2020.

# LEGISLATIVE SESSION - FACT SHEET

## 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 the Lower Mainland (UWLM).
- BH provides seniors with access to simple, non-medical home support services to help them stay independent in their own homes and connected to their communities for as long as possible.

### CURRENT SITUATION

- 81 core BH program sites currently operate across BC, serving over 260 communities, 4 of which are First Nations communities (Cowichan Tribes, Gitxsan Nation, Sto:lo Nation, and Tsleil-Waututh).[1]
- The BH services are provided by local non-profit organizations and delivered by a mix of volunteers, contractors, and staff. Services include light housekeeping, light yard work, snow shoveling, grocery shopping, minor home repairs, transportation to appointments and friendly visiting.
- From April 1, 2019 to March 31, 2020, BH delivered 191,147 services to 11,935 seniors and Elders.[2]
- BH data for 2020/21 is amalgamated with Safe Seniors, Strong Communities (SSSC) data. As of March 30, 2021, SSSC (including BH) delivered 816,457 services to 25,483 seniors and Elders.[3] (X-reference Safe Seniors, Strong Communities Fact Sheet). The expedited roll out of SSSC at the start of the COVID-19 pandemic put emphasis on service delivery to meet the immediate needs of BC seniors. SSSC used existing BH program structures and reporting processes, and all program data collection was rolled together. Independent BH data collection has resumed for 2021/22.
- Despite the inability to disaggregate BH data, the outcome of the Ministry's increased investment in Community Based Seniors Services programming last year is clear. BH was funded at $11 million in 2019/20 and $12.175 million in 2020/21; and, SSSC was funded at $2.5 million in 20/21. This represents a 33.4% increase in funding from one year to the next, but total service levels well exceeded that:

| | 2019/20 BH data | 2020/21 SSSC reported data (which includes BH services) | Percentage Change |
|---|---|---|---|
| **# seniors/Elders** | 11,935 | 25,483 | 114 % ↑ |
| **# services delivered** | 191,147 | 816,457 | 327 % ↑ |

### KEY FACTS

- Program sites are selected based on criteria such as the overall proportion of seniors in the area, and the number of seniors likely to require BH services. Seniors' organizations and other local and regional experts help guide the site selection process.
- Local circumstances determine fee structures and services available. Some services are provided at no cost, while a sliding scale is used to calculate fees for other services. Eligible seniors with low-income are not charged for any services, and aproximately 10% of seniors pay a full fee.
- A BH Advisory Committee, composed of representatives from UWLM, the Ministry, and community-based seniors services organizations was re-established in 2021. The committee provides an opportunity for information sharing, discussion and advice regarding administration of the BH program. The UWLM also engages with a broad range of subject matter experts and community partners from across the province through established communities of practice and collaboration channels.

Current Programs (entries in **bold** represent programs added in 2020/21)[4]:

| No. | Program Name | Lead Organization City | No. | Program Name | Lead Organization City |
|---|---|---|---|---|---|
| Vancouver Coastal Health Region (15 programs) | | | | | |
| 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 |

[1] United Way of the Lower Mainland email correspondence, January 11 and 13, 2021.
[2] United Way of the Lower Mainland email correspondence, January 11, 2021.
[3] Bc211 Safe Seniors weekly report for March 24-30, 2021.
[4] United Way of the Lower Mainland email correspondence, January 11, 2021.

# LEGISLATIVE SESSION - FACT SHEET

| No. | Program Name | Lead Organization City | No. | Program Name | Lead Organization City |
|---|---|---|---|---|---|
| 4 | Mount Pleasant BH | Vancouver | 12 | Sunshine Coast BH | Sechelt |
| 5 | Western Institute for the Deaf & Hard of Hearing 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 | | | |
| Interior Health Region (22 programs, including 4 new programs) | | | | | |
| 1 | Arrow Lakes BH | Nakusp | 11 | Lower Columbia BH | Trail |
| 2 | Ashcroft/Cache Creek BH | Kamloops | 12 | Nelson BH | Nelson |
| 3 | Boundary BH | Grand Forks | 13 | North Okanagan BH | Vernon |
| 4 | Castlegar BH | Castlegar | 14 | North Thompson BH | Clearwater |
| 5 | Central Okanagan BH | Kelowna | 15 | Penticton BH | Penticton |
| | | West Kelowna | 16 | Shuswap Region BH | Sicamous |
| | | Lake Country | 17 | South Okanagan BH | Oliver & Osoyoos |
| 6 | Columbia Valley BH | Invermere | 18 | Williams Lake BH | Williams Lake |
| 7 | Cranbrook BH | Cranbrook | **19** | **Peachland BH** | **Peachland** |
| 8 | Creston Valley BH | Creston | **20** | **Golden BH** | **Golden** |
| | | Crawford Bay | **21** | **Princeton BH** | **Princeton** |
| 9 | Kamloops BH | Kamloops | **22** | **Nicola Valley BH** | **Merritt** |
| 10 | Logan Lake BH | Logan Lake | | | |
| Northern Health Region (12 programs, including 1 new program) | | | | | |
| 1 | Dawson Creek BH | Dawson Creek | 7 | Prince George BH | Prince George |
| 2 | Fort St. John BH | Fort St. John | 8 | Prince Rupert BH | Prince Rupert |
| 3 | Gitxsan First Nations BH | New Hazelton | 9 | Quesnel BH | Quesnel |
| 4 | Granisle BH | Granisle | 10 | Robson Valley BH | Fort St. James |
| 5 | Kitimat BH | Kitimat | 11 | Terrace BH | Terrace |
| 6 | North Central BC BH | Fraser Lake | **12** | **Houston BH** | **Houston** |
| Fraser Health Region (14 programs) | | | | | |
| 1 | Abbotsford BH | Abbotsford | 8 | Mission BH | Mission |
| 2 | Burnaby BH | Burnaby | 9 | New Westminster BH | New Westminster |
| 3 | Chilliwack BH | Chilliwack | 10 | South Surrey/White Rock BH | Surrey |
| 4 | Delta BH | Delta | 11 | Stó:lo Territory BH | Agassiz |
| 5 | Hope/Fraser Canyon BH | Hope | 12 | Surrey-Newton BH | Surrey |
| 6 | Langley BH | Langley | 13 | Surrey-Whalley BH | Surrey |
| 7 | Maple Ridge/Pitt Meadows | Maple Ridge | 14 | Tri-cities BH | Port Moody |
| Vancouver Island Health Region (18 programs, including 2 new 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 |
| | | | | | **Total: 81 programs and over 260 communities served in BC** |

## FINANCIAL IMPLICATIONS

Since 2011/12, the Ministry and the Provincial Health Services Authority (PHSA) have provided $113 million to the UWLM 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, Government Financial Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division
May 10, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Cancer Strategy

### TOPIC

The Ministry of Health is committed to making BC a leader in the full continuum of cancer care by launching a 10-year cancer action plan.[1]

### CURRENT SITUATION

The Ministry will be submitting a Request for Decision to Cabinet seeking direction and authority to proceed with a Provincial Cancer Strategy (the Cancer Plan) developed by the BC Cancer Agency (BCCA) and the Ministry of Health.

### KEY FACTS

- With advances in screening, detection, and treatment, British Columbians are surviving and living with cancer in increasing numbers.
- Though our cancer incidence pressure increases steadily at 3% annually, the demand for individual services far exceeds this growth.[2] BC has experienced a near doubling of chemotherapy visit volumes within the last decade and similar pressure on both radiation and medical oncology consults and total acute care visits.[3]
- In 2019/20, 52% and 67% of British Columbians received a radiation or medical oncology consult within the 4-week benchmark, respectively, below the target of 90% of patients seen within 4 weeks.[4] This trend has deteriorated consistently by 2% per year.[5]
- In 2019/20, 90% of British Columbians received cancer radiation treatment within the 4-week benchmark meeting the provincial target. However, this is below the national average of 97%.[6]

Cabinet Confidences

[1] Ministerial Mandate Letter – November 26, 2020
[2] Email communication from Ryan Woods (BC Cancer, Director, Data and Analytics), January 5, 2021.
[3] Ibid
[4] Ibid
[5] Ibid
[6] Ibid
[7] The ICS was launched in 2017: https://www.fnha.ca/WellnessSite/WellnessDocuments/improving-indigenous-cancer-journeys-in-bc.pdf

- BCCA engaged with health system partners (e.g. Ministry program areas, regional health authorities, Indigenous health representatives) through summer and fall 2020 to ensure alignment of the proposed Cancer Plan with other health system priorities. These groups were similarly supportive of the Cancer Plan.

## FINANCIAL IMPLICATIONS

- The NDP platform highlights a 3-year operating budget commitment of $450M ($50M in 2020/21, $100M in 2021/22, and $300M in 2022/23).[8] In addition, the NDP made platform committed to build 2 new cancer centres (Nanaimo and Kamloops).[9]
- Following the presentation of the Cancer Plan to Cabinet, Treasury Board approval will be sought to confirm funding for capital and operating funds to support the Plan.

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**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division
May 25, 2021 – Marisa Herron obo Philip Twyford, ADM, Finance and Corporate Services Division

[8] Working for You: John Horgan's Commitments to BC. Retrieved from: https://www.bcndp.ca/sites/default/files/bcndp_platform2020_final4.pdf
[9] Ibid

# LEGISLATIVE SESSION - FACT SHEET

## Caregiver Supports

### TOPIC

- Family and friend caregivers play a profoundly important role in supporting people who are aging and people who have disabling health conditions.
- Over 8.1 million people, or 1 in 4 Canadians, is providing unpaid caregiving services to family members and friends.[1]
- Caregivers themselves need supports that provide them relief from the emotional and physical demands of providing care. Caregiver support services provided through home and community care include in-facility and in-home respite and adult day services.

### CURRENT SITUATION

**Adult Day Programs (ADP)**

- As of March 31, 2021, 15 out of 124 adult day program sites across the province were open, providing 2,231 out of the 29,226 spaces that would have been available at pre-pandemic operating capacity. [2]
- Current provincial guidance allows selective opening of ADP sites which: have a regional Medical Health Officer (MHO) approved COVID-19 operating plan; and operate in a stand alone building or a building other than a long-term care home or assisted living residence; or, at the site of a long-term care or assisted living residence where there is NO shared space, entrance, staff, activity, or equipment.
- As of March 31, 2021, the following distribution of ADP sites were open: Island Health – 13 sites (1929 spaces); Vancouver Coastal – 1 site (174 spaces); Northern – 1 site (128 spaces); Fraser – no sites open; and Interior – no sites open.
- All health authorities have added alternate service delivery to support clients and caregivers such as virtual wellness check-ins, meal delivery, activity/craft supply delivery, etc.
- In 2020/21, a total of 1,055 British Columbians received ADP (83% decrease from 2016/17 baseline) and over 12,000 days of ADP were provided (95% decrease from 2016/17 baseline), reflecting a material decrease due to COVID-19 related closures and service reductions. [3]

**Overnight/In-Facility Respite**

- In-facility respite is currently available across all health regions, at the direction of regional MHOs.
- In-facility respite service has experienced significant reduction in service volumes due to the suspension of service to contain the spread of COVID-19.
- In 2020/21, a total of 913 clients received overnight respite, a 70% decrease from baseline in 2016/17. [5]
- Nearly 29,000 overnight respite days were provided in 2020/21, a 68% decrease from baseline in 2016/17. [5]

**In-Home Respite**

A temporary COVID-19 response policy, Expanded In-Home Respite, enables respite visits for eligible clients whose caregivers are at high risk of burnout and/or clients whose home living situation is at risk of breaking down due to COVID-19. While the respite visit focus is wellness and companionship (i.e., social/recreational activities and/or cognitive stimulation activities), routine household tasks such as light housekeeping and meal preparation are encouraged to help lighten caregiver duties.

### KEY FACTS

- Health care providers use the RAI Home Care Assessment to identify caregiver/client need.
- 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.

**Adult Day Programs**

- 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.

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[1] Caregiver Facts, Carers Canada (Captured in April 2021)
[2] ADP Re-opening Report, P13
[3] HCC Progress Report, 2020/21 Period 13, last accessed May 5, 2021

- On March 18, 2020, all health authority funded/operated ADPs across BC were suspended to help prevent the spread of COVID-19 and prioritize healthcare resource allocation.
- On August 26, 2020, the Ministry of Health approved a selective re-opening of ADP sites that operate in a standalone facility or are co-located within a long-term care home but do not share space/staff/equipment.
- ADPs were suspended again in Vancouver Coastal and Fraser Health regions on November 27, 2020, and across the Interior Health region on December 7, 2020, in response to increasing numbers of COVID-19 cases in these regions.
- As of February 23, 2021, the Ministry advised Vancouver Coastal and Fraser Health authorities to consider resumption of ADP at the direction of their respective MHOs.

**Overnight/In-Facility Respite**

- In-facility respite provides short term care for clients in a licensed long-term care facility. This supports caregivers by enabling a break and time away from caregiving while clients receive safe, professional care.
- On March 18, 2020, health authorities were advised to temporarily suspend in-facility respite to help prevent the spread of COVID-19, prioritize healthcare resource allocation, and address acute care surge capacity, except in circumstances of intolerable risk.
- On July 15, 2020, the Ministry approved the resumption of in-facility respite services where the facility complies with regional MHO directions and implements mandatory isolation requirement for new clients.
- On November 27, 2020, in-facility respite was suspended again in Vancouver Coastal and Fraser Health regions in response to increasing numbers of COVID-19 cases in these regions.
- As of February 23, 2021, the Ministry has advised Vancouver Coastal and Fraser Health authorities to consider resumption of in-facility respite services at the direction of their respective MHOs.

**After Hours Palliative Nursing Service** (X ref Palliative Care Fact Sheet)

An advice line available to caregivers and clients, supporting individuals nearing end of life, the After Hours Palliative Nursing Service is a provincial evening and over-night telephone service where caregivers can talk through issues and concerns with a nurse. Complex calls can be escalated to a specialist palliative care nurse.

**First Link** (X ref Dementia Care Fact Sheet)

The Alzheimer Society of BC's First Link®/Premier lien® program, available to people affected by Alzheimer's disease and other forms of dementia, assists caregivers to identify appropriate support services and to respond to common challenges that may arise at various stages when caring for a person with dementia.

**Seniors' Guide**

The BC Seniors' Guide is an invaluable resource for seniors and caregivers, providing information about services and supports available throughout the province. Available in 7 languages (print and electronic), the Guide has information about benefits, health, lifestyle, housing, transportation, finances, safety and more.

**Family Caregivers of BC**

Family Caregivers of British Columbia 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.

## FINANCIAL IMPLICATIONS

- Budget 2021 provides $68 million over the 3 years of the fiscal plan ($22.67M annually, flat-lined) to increase support for home care services, including increasing care aides and community providers.
- The Ministry of Health is investing $75M over 3 years to expand respite care and adult day programs, helping both seniors and their loved ones.[4]
- In April 2020, Government announced it was doubling 2020/21 funding for Family Caregivers of BC to $1M, helping support both caregivers and seniors as part of BC's emergency COVID-19 response plan.[5]

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**Approved:**

May 7, 2021 – Teri Collins, ADM, Health Services Division
May 17, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
May 20, 2021– Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[4] BC Gov News Release, June 2018
[5] BC Gov News Release, August 2020

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Response for Clients in Community

## TOPIC

Health authorities and the Ministry of Health have deployed strategies and policies to support individuals to maintain their home living situation during the pandemic and avoid unnecessary use of acute care/emergency services; and, avoid premature admission to long-term care (LTC) or assisted living (AL).

## CURRENT SITUATION

Home Health Services

- Health authorities and the Ministry implemented COVID-19 response policies and strategies to: continue delivering home health services safely while prioritizing clients with the greatest care needs; maintain service continuity for clients (including shifting to virtual care where possible and appropriate); minimize risk of transmission and manage personal protective equipment supplies via enhanced infection prevention and control protocols; and actively manage the supply and allocation of health human resources.
- COVID-19 Home and Community Care Infection Prevention and Control Guidance has been implemented at each health authority and was posted to the BCCDC website as of January 18, 2021.
- Temporary COVID-19 policies enable health authorities to provide additional supports to clients who are at increased risk of having their home living situation break down: Expanded In-Home Respite and the Non-Clinical Support Worker policy.
- Health authorities are managing interruptions in the home support workforce due to pandemic related staff sickness/absences, redeployments, and spillover impacts of the single site order – all exacerbating the existing Community Health Worker shortage.

Adult Day Programs (ADP)

- As of March 31, 2021, 15 out of 124 ADP sites across the province were open, providing 2,231 out of the 29,226 spaces that would have been available at pre-pandemic operating capacity.[1] Provincial guidance allows selective opening of ADP sites which:
    - have a regional Medical Health Officer (MHO) approved COVID-19 operating plan; and,
    - operate in a stand alone building or a building other than a LTC home or AL residence; or, at the site of an LTC or AL residence where there is NO shared space, entrance, staff, activity, or equipment.
- As of March 31, 2021, the following distribution of ADP sites were open:
    - Island Health – 13 sites (1929 spaces)
    - VCH – 1 site (174 spaces)
    - NHA – 1 site (128 spaces)
    - Fraser – no sites open
    - Interior – no sites open
- All health authorities, in some capacity, have allocated Adult Day Programs (ADP)staff to provide virtual services like wellness check-ins, meal delivery, activity/craft supply delivery etc.

In-Facility Respite

In-facility respite is currently available across all health authorities at the direction of the Chief MHOs.

## KEY FACTS

Home Health

Health authorities have implemented operational policies to support the prioritization of home health clients and services, virtual care and telehealth options where appropriate, and practices to manage health human resources to maintain service capacity.

- A temporary COVID-19 policy, Expanded In-Home Respite, targets clients whose caregivers are at high risk of burnout and/or clients whose home living situation is at risk of breaking down. While the primary focus of the respite visit is wellness and companionship (i.e., engaging with the client through social/recreational activities and/or cognitive stimulation activities), workers are encouraged to perform routine household

[1] ADP Re-opening Report, P10

tasks, Instrumental Activities of Daily Living (IADL), such as light housekeeping and meal preparation during the visit where this can be safely achieved without detracting from the wellness focus. These tasks were previously out of scope for home support services, unless deemed necessary to address a safety concern.

- A temporary COVID-19 policy, Non-Clinical Support Workers, provides for an entry level home support role to support eligible clients with non-clinical/non-direct healthcare supports (IADL), such as routine household tasks and companionship. The policy is complementary to the Expanded In-Home Respite Policy, expanding the workforce available to provide respite visits and assistance with household tasks. The policy also supports health authorities in recruiting/preparing new workers for a career in healthcare.

Adult Day Programs (ADP)

- ADPs provide eligible clients with a range of personal and health care supports in community settings and provide caregivers relief from caregiving duties.
- On March 18, 2020, the Ministry directed the temporary suspension of health authority operated/funded ADP due to risk of community COVID-19 transmission and proximity to LTC facilities.
- On August 26, 2020, the Ministry approved a selective re-opening of ADP sites that are operating in a stand-alone facility, or, are co-located within a LTC home, but do not share space/staff/equipment. Re-openings were contingent on adherence to Ministry developed guidelines and required re-opening plans to be approved by a regional MHO.
- ADPs were suspended again in Vancouver Coastal and Fraser Health regions on November 27, 2020, and across the Interior Health region on December 7, 2020, in response to increasing numbers of COVID-19 in these regions.
- As of February 23, 2021, the Ministry advised Vancouver Coastal and Fraser Health authorities to consider resumption of ADPs at the direction of their respective MHOs.
- The Ministry continues to monitor and track the reopening of ADPs by facility and setting.

Respite Services

- In-facility respite provides short term care for clients in a licensed long-term care facility. This supports caregivers by enabling a break and time away from caregiving while providing safe, professional care.
- On March 18, 2020, the Ministry temporarily suspended the provision of in-facility respite services to mitigate the risk of transmission through client transfers between care facilities and communities. Clients with circumstances of intolerable risk were exempted from this direction.
- On July 15, 2020, The Ministry approved the resumption of in-facility respite services in all regional health authorities, with certain limitations:
    - Restriction on respite in facilities with active COVID-19 outbreaks.
    - In-facility respite must follow regional MHO direction and require a 14-day isolation for all clients.
- On November 27, 2020, in-facility respite was suspended again in Vancouver Coastal and Fraser Health in response to increasing numbers of COVID-19; however, as of February 23, 2021, the Ministry advised Coastal and Fraser Health they may resume in-facility respite, at the direction of their MHOs.

Health Career Access Program

Advice/Recommendations

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 24, 2021 – Darlene Therrien obo Ian Rongve, ADM, COVID Response and Health Emergency Management Division
May 7, 2021 - Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Dense Breast and Supplementary Imaging

### TOPIC

- Dense Breasts Canada has long been advocating for breast density reporting and follow-up supplemental testing across Canada.
- In December 2018, the Medical Services Plan (MSP) began covering screening breast ultrasound for patients with dense breasts, when requested by a primary care provider, based on their clinical judgment.

### CURRENT SITUATION

There are known access and wait time issues for breast imaging services, which were amplified when BC began providing the breast composition scores to patients and their practitioners on their screening mammography reports.

### KEY FACTS

Dense Breast Background

- Breast density is measured by comparing the amount of dense (fibrous and glandular) to non-dense (fatty) tissue within the breast when assessing a mammogram image.
- It is scored by a Radiologist using the Breast Imaging Reporting and Data System (BI-RADS) on a four-point letter scale (A-D). The C and D categories are commonly referred to as dense breasts.
- A patient may have different breast density scores over time, as density can naturally change, often decreasing with age or vary between mammograms subjective to radiologist scoring.
- Research suggests that having higher density can have two effects: 1) an increase in overall 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), and body mass index; and 2) a reduced ability to detect abnormalities by mammography due to a masking effect.
- Even though dense breast tissue is a risk factor for breast cancer, having dense breast tissue on its own does not mean a patient is at high risk for developing cancer in their lifetime.
- The distribution of BI-RAD scores of BC participants in the Breast Screening Program, 2019[1] are:

| BI-RAD Score | Description | % | # of Females |
|---|---|---|---|
| **A** | Almost entirely fatty | 15 | 39,961 |
| **B** | Scattered areas of fibroglandular tissue | 44 | 117,218 |
| **C** | Heterogeneously dense; may obscure small masses | 34 | 90,578 |
| **D** | Extremely dense; lower mammographic sensitivity | 7 | 18,648 |
| | **Total Number of Participants** | | **266,405** |

Reporting of Breast Density Scores

- Dense Breast Canada has long been advocating for breast density reporting and follow-up supplemental testing across Canada.
- On October 1, 2018, BC became the first province in Canada to provide breast density assessments to patients and their doctors following screening mammogram.

Supplementary Imaging for Patients with Dense Breasts

- While mammography remains the recommended imaging modality for breast cancer screening, some women with dense breasts may benefit from supplementary ultrasound testing to find additional cancers with negative mammogram results.
- However, there is insufficient evidence to support supplemental testing based solely on dense breast tissue as the risk factor. Given this lack of evidence, the Canadian Task Force on Preventive Health Care and the U.S. Preventive Services Task Force do not recommend supplemental testing despite the increased risk.

[1] 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

- In December 2018, the Medical Services Plan (MSP) began covering screening breast ultrasound for patients with dense breasts, when requested by a primary care provider, who feels that their patient's situation warrants further investigation.

Breast Imaging Wait Times

- There are known wait time issues with diagnostic mammography, screening and diagnostic breast ultrasounds, and all non-emergency ultrasounds[2] due to a lack of resources and capacity. There are limited facilities currently offering breast screening ultrasounds.
- There are no known issues with wait times for screening mammography. Screening mammograms are funded by the BC Cancer's Breast Screening Program and provided under contract at 36 facilities (i.e. health authorities, community imaging clinics) and 3 mobile vans.[3]
- Long wait times may lead to delayed diagnosis and treatment, causing unnecessary patient stress and anxiety.
- With the addition of 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 700% from current bilateral ultrasound volumes. In 2019/20, there were 95,317 unilateral breast ultrasounds performed, and 15,080 of those were bilateral exams.[4]
- BC Women's Hospital & Health Centre reports wait time for the first diagnostic breast imaging is 3 to 4 weeks, the recommended wait for the first diagnostic breast imaging after an abnormality has been detected is 1 week.[5] Urgent cases typically have shorter waits as they are fast-tracked.
- On average, approximately 9% (23,710 in 2019) of women who had a screening mammogram had an abnormal result requiring additional diagnostic testing to investigate.[6]
- The national target for diagnostic interval is 90% of women with abnormal mammogram findings receive a diagnosis within 5 weeks (when biopsy is not required) or within 7 weeks (when biopsy is required).
- In 2019, 83.0% of women (aged 50-69) with no tissue biopsy performed and 66.3% of women (aged 50-69) with tissue biopsy performed met the national target.[7]

Mitigation Strategies

- Health authorities are actively trying to recruit more radiologists and sonographers that have a sub-speciality skillset in breast imaging. There is a known shortage of sonographers in the province, in which the ministry is working with health authorities and the Ministry of Advanced Education to train more sonographers.[8]
- In April 2018, MSP billing rules were updated to allow radiologists to bill a second diagnostic breast imaging procedure performed on the same day. This was to incentivize a same day service model of breast imaging and ultrasound-guided biopsy procedures.
- Work had begun to provide recommendations to the Ministry on how to increase access to breast ultrasound services for individuals with high-density breast composition that were evidence-based and can be deployed using a standardized protocol equitably and sustainably across the province. However, this work has been postponed due to shift in priority to respond to the COVID pandemic.

## FINANCIAL IMPLICATIONS

The increase of 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 breast is unknown.

**Approved:**

January 26, 2021 – Teri Collins, ADM, Health Services Division

February 2, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

[2] FACT SHEET: Non-Emergency Ultrasound Wait Times in BC. NOTE: Ultrasound wait times are not collected by theMministry.

[3] SOURCE: BC Cancer Agency, BC Cancer Breast Screening 2019 Program Results, September 2020, pg. 9. :

[4] MSP Database for 2019/20 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/ffs_complete.pdf

[5] SOURCE: PHSA, Confidential Issue Note: Breast Imaging Services Wait Times, February 4, 2020.

[6] SOURCE: BC Cancer Agency, BC Cancer Breast Screening 2019 Program Results, September 2020, pg. 28.

[7] SOURCE: BC Cancer Agency, BC Cancer Breast Screening 2019 Program Results, September 2020, pg. 42.

[8] Refer to FACT SHEET: Diagnostic Medical Sonography and FACT SHEET: Non-Emergency Ultrasound Wait Times in BC for further information.

# LEGISLATIVE SESSION - FACT SHEET

## Diagnostic Imaging Strategy

### TOPIC

- In December 2020, government renewed their commitment to provide faster care, so patients will have shorter wait times for the care they need.
- This includes adding more Magnetic Resonance Imaging (MRI) machines in high-demand areas to reduce wait times and bring new approach to build on the success of the Surgical Renewal Plan and an increase in diagnostic procedures.

### CURRENT SITUATION

- For 2020/21, the focus continues on increasing capacity and reducing wait times for MRI machines through a variety of strategies, including: optimizing existing capacity; increasing new capacity and efficiency; ensuring exams performed are appropriate; increasing health human resources capacity; improving waitlist management; and continuing to make data improvements for standardized data collection and reporting.
- As part of the provincial COVID-19 pandemic response, the Ministry of Health directed health authorities to postpone all non-urgent MRI exams between March 19 to May 14. It is estimated this resulted in loss of 30,868 MRI exams during an 8-week period (P13 - 02).[1]
- It is estimated a further reduction of 16,613 MRI exams were due to additional Infection and Prevention Control (IPC) protocols in P03 - 07. Modified IPC protocols were implemented in P08 to reduce inefficiencies.
- These services have now resumed, and health authorities are working on increasing capacity to move through the backlog of postponed patients.

### KEY FACTS

MRI Volumes[2]

In 2020/21, a total of 247,106 MRI exams were completed. This is a decrease of 5,421 MRI exams over 2019/20 actuals and expected given the impacts of COVID-19.

- In the first 2 years of the strategy, the MRI volume target was met and exceeded.
- In 2019/20 the public target was 248,369, the actual was 252,527, which was 4,158 over target.
- In 2018/19 the public target was 225,000, the actual was 233,368, which was 8,368 over the target.
- Over the past five years, significant progress has been made as the number of MRI exams have increased by 71,399 exams in 2020/21 compared to 2016/17, which is 41%.

**Table 1: MRI Exam Volumes, Actuals, 2016/17 – 2020/21[3]**

| HA | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | # change 2016/17 to 2020/21 | % change 2016/17 to 2020/21 |
|---|---|---|---|---|---|---|---|
| IHA | 20,948 | 20,726 | 27,219 | 34,423 | 38,640 | 17,692 | 84% |
| FHA | 48,810 | 55,723 | 65,302 | 73,581 | 73,163 | 24,353 | 50% |
| VCHA | 50,488 | 57,286 | 64,606 | 64,616 | 57,675 | 5,187 | 10% |
| VIHA | 38,042 | 38,496 | 49,345 | 50,923 | 49,429 | 11,387 | 30% |
| NHA | 6,331 | 7,536 | 14,084 | 15,663 | 14,400 | 8,069 | 127% |
| PHSA | 9,088 | 9,753 | 12,812 | 13,321 | 13,799 | 4,711 | 52% |
| **BC** | **175,707** | **189,520** | **233,368** | **252,527** | **247,106** | **71,399** | **41%** |

MRI Wait Times[4]

- For 2020/21:
  - the 50th (median) wait time for completed outpatient MRI was 56 days (year-to-date) and was 37 days

[1] HAMIS – Extract as of 2021-05-21, Medical Imaging Report, P01 2021/22, PAS 3000_0080. Calculated by comparing 2019/20 P12 actuals multiplied by 3 to the sum of 2019/20 P13 to 2020/21 P02 actuals.

[2] HAMIS – Extract as of 2021-05-21, Medical Imaging Report, P01 2021/22, PAS 3000_0080.

[3] There may be minor discrepancies with some numbers that have been in previous internal or publics reports. This is because these numbers have been reinstated afterwards.

[4] Wait Times: MIWT – Snapshot# 165, extract as of 2021-05-19, P01 2019/20 to P01 2021/22

in March 2021 (P13).
  - 90th percentile wait time for completed outpatient MRI was 188 days (year-to-date) and was 146 days in March 2021 (P13).
- Wait times for MRI have previously been reported comparing P01 to P13 of the fiscal year. In 2020/21 wait times for MRI are not comparable from P01 and P13, since wait times are recorded when the exam has been completed and in P01, non-urgent exams were being postponed and only urgent exams (those with a benchmark wait time of 7 days and under) were performed, skewing the wait times.

MRI Operating Hours[5]

- At the end of 2020/21 (March 2021), MRI units in BC were operating for a total of over 4,800 hour per week, and over 2,000 more hours per week than August 2017.
- 23 MRI units operated over the 112 hours per week benchmark (16 hours / day x 7 days). Of those, 8 MRI units operated at 168 hours per week (24 hours / day x 7 days).
- Additional hours were achieved by expanding evening, weekend and/or holiday shifts, and operationalizing net-new MRI units.

MRI Unit Inventory

- There are 42 MRI units in BC currently, with IHA = 6; FHA = 12; VCHA = 9; VIHA = 9; NHA = 3; and PHSA = 3.
- 17 net-new MRI units operationalized since August 2017, including: **1)** Mills Memorial Hospital in Terrace – Aug 2017; **2)** Fort St. John Hospital – Sept 2017; **3)** North Island Hospital – Campbell River – Sept 2017; **4)** North Island Hospital – Comox Valley – Oct 2017; **5)** BC Children's – Oct 2017; **6)** East Kootenay Regional Hospital in Cranbrook - June 2018; **7)** Abbotsford Outpatient MRI Clinic in Abbotsford - Dec 2018; **8)** Surrey Outpatient MRI Clinic in Surrey – March 2019; **9)** Jim Pattison Outpatient Care and Surgery Centre in Surrey – May 2019; **10)** Penticton Regional Hospital – Aug 2019; **11)** Vernon Jubilee Hospital – Sept 2019; **12)** Royal Jubilee Hospital – Oct 2019; **13)** Nanaimo Regional General Hospital – March 2020; **14)** Ridge Meadows Hospital in Maple Ridge – Nov 2020; **15)** Langley Memorial Hospital – Dec 2020; **16)** Granville Outpatient MRI Clinic in Vancouver - June 4th 2021; and **17)** St Paul's Hospital– June 14th, 2021.
- There is one net-new MRI unit to open at Vancouver General Hospital in 2022/23.

2021/22 Key Highlights

- Continuing to optimize existing capacity and add net-new capacity. Advice/Recommentations Advice/Recommentations . This is over 100,000 more MRI exams when compared 2016/17.
- Building on the successes of MRI access and expanding the scope to other critical diagnostic imaging modalities, like computed tomography, or commonly known as a CT scan.
- Ensuring there is a sustainable supply of essential personnel through enhancing education and training opportunities and continuing to implement care models that optimize staff and patient throughput.
- Building greater transparency of waitlists by implementing best practices to manage waitlists and improving communications on waitlist status for patients and their referring practitioners.
- Continuing to respond to and recover from the pandemic by ensuring services are provided as safely as possible for both our patients and our essential personnel that performs these services.

## FINANCIAL IMPLICATIONS

The Ministry of Health allocated $175 million in targeted funding in 2020/21 to support the Surgical and Diagnostic Imaging Strategy. Of the $175 million to support the Strategy, up to $33.06 million was available to support imaging activity.

**Approved:**

May 17, 2021 –Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
May 25, 2021 –Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 9, 2021 – Kristy Anderson obo Teri Collins, ADM, Health Services Division

[5] Source: Operating Hours: MRI Weekly Operating Hours: Manual submissions by HA, P13 2020/21.

# LEGISLATIVE SESSION - FACT SHEET

## Emergency Department Access

### TOPIC

Access to timely emergency services is important to both patients and health care providers. Emergency department (ED) crowding is impacted by patient flow within the hospital, inpatient bed capacity/availability, and access to primary, community and long-term care services.

### CURRENT SITUATION

The unprecedented events following the outbreak of COVID-19 created a very different environment for EDs; visits across the province were significantly reduced. The focus shifted from managing volume and patient flow to adjusting clinical triage processes, enhancing infection prevention and control practices, and redesign of physical spaces in response to the pandemic.

### KEY FACTS

ED Visit Volumes

- Between 2014/15 and 2019/20, prior to the COVID-19 pandemic, the average annual growth rate for provincial ED visits was 1.9%.
- During the COVID-19 pandemic, ED visits dropped across all health authorities except for Interior Health.
- Comparison between April 1, 2019 – March 31, 2020 and April 1, 2020 – March 31, 2021 shows a provincial reduction of -12.8%.
- PHSA showed the most significant reduction at -34.6%.

**Table 1:** ED Visits by Health Authority, Comparison between 2019/20 and 2020/21 (Period 1-13)[1]

| Health Authority | ED Visits, 2019/20 Period 1-13 (April 1, 2019 – Mar 31 2020) | ED Visits, 2020/21 Period 1-13 (April 1, 2020 – Mar 31 2021 | Percent Change from 2019/20 (P1-13) |
|---|---|---|---|
| Interior Health Authority | 520,774 | 522,433 | 0.3% |
| Fraser Health Authority | 702,180 | 586,339 | -16.5% |
| Vancouver Coastal Health Authority | 431,167 | 359,816 | -16.5% |
| Vancouver Island Health Authority | 443,036 | 391,309 | -11.7% |
| Northern Health Authority | 272,240 | 215,214 | -20.9% |
| Provincial Health Services Authority | 46,127 | 30,159 | -34.6% |
| **British Columbia** | **2,415,524** | **2,105,270** | **-12.8%** |

Examples of specific actions taken to reduce the number of patients presenting to EDs who did not require emergent care during the pandemic include:

- **Expansion of HealthLink BC 8-1-1 services to include HEiDi (High Emergency iDoctors in assistance):** HEiDi is real-time virtual support service that provides nurses working on the 8-1-1 line access to full-service doctors to assist with more complex cases, decision support on whether the patient needs to go to the ED or can be managed in the community, and assistance with call volumes.
- **Urgent follow-up outside of ED:** Many EDs worked with nearby Urgent and Primary Care Centres (UPCCs) to provide urgent follow-up appointments at those UPCCs for patients who did not require emergent care.
- **Virtual triage:** Fraser Health has been piloting virtual triage, which involves directing patients who have accessed any existing Fraser Health services to the Virtual Care Nurse, particularly after-hours and on weekends. The Virtual Care Nurses (RNs with Emergency and Primary Care experience) complete an assessment and advise or connect callers with the service that best meets their needs. The service helps direct and link callers to available health services including the integrated system of primary and community care. Individuals who might consider using the ED for non-emergency needs are linked to a range of available urgent and primary care options.

[1] Source: *ED Report – 2020_21 – Period13 ED Visits on HSIAR SharePoint*

ED Wait Times

- Relationships exist between 'time waiting for inpatient beds following decision to admit,' 'total length of stay for ED patients admitted to hospital' and hospital occupancy and alternative level of care rates. Higher occupancy rates contribute to ED congestion. (See ***Hospital Congestion*** Fact Sheet.)
- BC's performance in relation to benchmarks established by the Canadian Association of Emergency Physicians (CAEP) is shown in Table 2 below.

**Table 2** ED Wait Times for BC Facilities Reporting to NACRS, Comparison between 2019/20 and 2020/2021 (as of Dec 10, 2020)[2]

| ED Wait Time Indicator (Wait Times in Hours) | 2019/20 | | | | 2020/21 (as of Dec 10, 2020) | | | |
|---|---|---|---|---|---|---|---|---|
| | National Benchmark [3]for Median | BC Hospitals - Median (% of patient visits meeting benchmark) | National Benchmark for 90th Percentile | BC Hospitals – 90th percentile (% of patient visits meeting benchmark) | National Benchmark for Median | BC Hospitals - Median (% of patient visits meeting benchmark) | National Benchmark for 90th Percentile | BC Hospitals - 90th percentile (% of patient visits meeting benchmark) |
| Time Waiting for Physician Initial Assessment in the ED (excludes patient left without being seen) | 1.0 | **1.1 (45%)** | 3.0 | **3.1 (89%)** | 1.0 | **0.8 (58%)** | 3.0 | **2.4 (94%)** |
| Time Waiting for Inpatient Bed After Decision to Admit | 2.0 | **6.4 (25%)** | 8.0 | **40.7 (54%)** | 2.0 | **3.7 (31%)** | 8.0 | **23.4 (68%)** |
| Total Length of Stay for ED Patients Admitted to Hospital | 8.0 | **13.0 (31%)** | 12.0 | **46.3 (47%)** | 8.0 | **9.5 (41%)** | 12.0 | **29.2 61%** |
| Length of Stay for High Acuity Patients Discharged Directly from the ED (CTAS[4] 1, 2 and 3) | 4.0 | **3.4 (61%)** | 8.0 | **7.0 (94%)** | 4.0 | **3.2 (65%)** | 8.0 | **6.8 (94%)** |
| Length of Stay for Low Acuity Patients Discharged Directly from the ED (CTAS 4 and 5) | 2.0 | **2.1 (48%)** | 4.0 | **4.6 (85%)** | 2.0 | **1.9 (54%)** | 4.0 | **4.3 (88%)** |

G = meets or exceeds benchmarks set by CAEP  Y= slightly over benchmark set by CAEP (within one hour)  R = did not meet benchmark set by CAEP (by more than one hour)

During the COVID-19 pandemic, BC met or exceeded established benchmarks in wait time for initial assessment, and in length of stay for high acuity (CTAS levels 1, 2 and 3). Length of stay for low acuity patients (CTAS 4 and 5) exceeded the benchmark for the median and was slightly over or the 90th percentile. Time waiting for an inpatient bed and total length of stay continue to be unmet but with significant improvements noted.

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

April 29, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
May 7, 2021 – Janice Butler obo Teri Collins, ADM, Health Services Division

[2] *Data Source: HSIAR ED Dashboard (with information on ED sites in BC that are reporting to NACRS) on February 9, 2021*
[3] These are the benchmarks published by the Canadian Association of Emergency Physicians (CAEP) in November 2013
[4] The Canadian Triage and Acuity Scale (CTAS) is a tool used both nationally and internationally to allow emergency departments and their staff to prioritize patient care requirements. The scale ranges from Level 1 (conditions that are a threat to life and limb) to Level 5 (non-urgent).

# LEGISLATIVE SESSION - FACT SHEET

## Family Councils

### TOPIC

Family Councils provide an important forum for families of those in long-term (LTC) homes for internal issues identification and resolution, education and support to improve the quality of life for people in care.

### CURRENT SITUATION

- In 2015, the Vancouver Island Association of Family Councils (VIAFC) submitted a "Proposal for Change – Supporting Residents in Care" which calls for the Ministry of Health to "develop and adopt regulations and policies that entrench opportunities for Family Councils in all residential care facilities within BC and require all public and private facilities to cooperate with and assist Family Councils"
- In November 2020, the Office of the Seniors Advocate (OSA) released a report entitled "Staying Apart to Stay Safe" which made several recommendations for system change. One recommendation of the Report is for the Ministry to work with the OSA to establish a provincial association of LTC and assisted living Resident and Family Councils. The proposed Association would work with health authorities and the Province to promote best practices and advance quality of life for residents of LTC and assisted living by bringing together the voices of residents and their families.
- In December 2020, the Action for Reform of Residential Care Association started a letter writing campaign advocating for the Proposal and Report to be implemented.

### KEY FACTS

- The Residential Care Regulation (RCR) has specific requirements for LTC homes to provide support to Family Councils and/or Family and Resident Councils and to offer an opportunity, at least annually, to create a Family Council where none currently exists.
- Ministry staff recently canvassed health authorities to determine if there had been any complaints about Family Councils and learned there were no complaints submitted to licensing between January 2018 and September 2020.
- The Ministry currently has regulations and policies in place to support Family Councils. The RCR supports Family Councils by requiring an operator to provide an opportunity, at least once a year, for persons in care and their representatives, family members and contact persons to meet with the operator.
- This is an important provision as it requires that operators acknowledge, support, and communicate with the Family Council for the purposes of enhancing and improving the quality of life of persons in residential care.
- Additionally, under section 6H in the Home and Community Care Policy Manual, health authorities have a responsibility to ensure Family Councils are encouraged and supported.

Advice/Recommentations

### FINANCIAL IMPLICATIONS

N/A

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**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Foundry

### TOPIC

Foundry, a program of Providence Health Care (PHC), is a provincial network of integrated youth centres and virtual supports, offering health and wellness services and resources for youth ages 12-24 and their families. The Foundry network includes more than 200 partners from across British Columbia and is supported by provincial, federal, and philanthropic funding. The Foundry Central Office (FCO) provides leadership support for all Foundry initiatives.

### CURRENT SITUATION

- There are currently 11 Foundry centres open across the province, offering in-person and virtual services.
- As part of *A Pathway to Hope*, the Province committed to expanding Foundry by a further 8 centres, for a current total of 19 province-wide (see *Table 1* on p.2 for a list of all centres and their implementation status). Through Budget 2021, funding is available for 4 additional Foundry centres with planning starting in fiscal year 2023/24.
- Each integrated centre offers primary care, mental health and substance use (MHSU) services, peer support, and social services under one roof. The Foundry centre model relies heavily on integrating existing services in the community through a partnership between provincial ministries, regional health authorities, community lead agencies, and other community and non-profit organizations.
- In January 2018, Foundry and BC Children's Hospital (BCCH) launched foundrybc.ca, a digital hub to simplify access to health and wellness resources, tools and supports for young people and their families.
- Foundry is working with Indigenous young people, families, communities, and partner organizations, including First Nations Health Authority and Métis Nation BC, to develop a cultural safety and humility framework and to ensure the delivery of culturally safe and appropriate care across all Foundry services.

Foundry Virtual

- Foundry Virtual, a program offering virtual supports to young people and their families, was developed through a partnership between Foundry, BCCH, TELUS Health, and the Ministries of Health (the Ministry) and Mental Health & Addictions.[1] Initial plans were to pilot Foundry Virtual in 2020/21; however, the Province supported an accelerated launch in response to the COVID-19 pandemic.
- In April 2020, Foundry Virtual started by offering virtual counselling and peer support sessions and has since expanded to include the full scope of their service model.
- From April 2020 to January 2021, Foundry Virtual has provided supports to 1,029 unique youth through 2,499 visits. A further increase in demand is anticipated with the recent launch of a dedicated mobile app.[2]

### KEY FACTS

- From April-December 2020, a total of 13,684 unique youth accessed Foundry. Service utilization rates were impacted by the COVID-19 pandemic, but have recently returned to pre-pandemic levels.[3]
- Foundry Virtual served 1,029 unique youth though 2,499 visits from April 2020 to January 2021.[4]
- Since launching in January 2018, foundrybc.ca has had over 931,920 visits and 2,397,687 page views.
- From May 2018 to July 2020, 9.4% of Foundry clients identified as First Nations or Métis. This reflects provincial representation, with 8.5% of BC youth identifying as First Nations or Métis in the 2016 Canadian Census.[5]

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[1] For more info, see HSMIT's *Mental Health and Substance Use Virtual Clinic Project* fact sheet
[2] Foundry Central Office. (January 2021). Foundry Virtual Toolbox Data. Reporting Period: April 2020 to January 2021, pp.1-2.
[3] These numbers are inclusive of Foundry Virtual, and are compiled from Q1, Q2, and Q3 Foundry Toolbox Data reports.
[4] Foundry Central Office. (January 2021). Foundry Virtual Toolbox Data. Reporting Period: April 2020 to January 2021, pp.1-2.
[5] Pullman, A. (September 2020). An External Evaluation of Foundry: BC's Network of Health and Social Service Centres for Youth, pp. 119, 138.

**Table 1: Foundry Centre Locations – Open and In Development[6]**

| Location | | Lead Agency | Health Authority | Open Date |
|---|---|---|---|---|
| Existing / Open Centres | Campbell River | The John Howard Society of North Island | Island | April 2017 |
| | Victoria | Victoria Youth Clinic | Island | May 2018 |
| | North Shore | Vancouver Coastal Health | Vancouver Coastal | Sept. 2017 |
| | Vancouver-Granville | Providence Health Care Society | Vancouver Coastal | March 2015 |
| | Kelowna | Canadian Mental Health Association | Interior | Sept. 2017 |
| | Penticton | OneSky Community Resources | Interior | July 2019 |
| | Prince George | YMCA of Northern BC | Northern | Oct. 2017 |
| | Abbotsford | Archway Community Services | Fraser | June 2018 |
| | Ridge Meadows | Maple Ridge/Pitt Meadows Community Services | Fraser | March 2020 |
| | Richmond | Vancouver Coastal Health | Vancouver Coastal | July 2020[7] |
| | Terrace | Terrace & District Community Services Society | Northern | August 2020[8] |
| In Development | Burns Lake | Carrier-Sekani Family Services | Northern | *By 2022/23* |
| | Comox Valley | John Howard Society of North Island | Island | *By 2022/23* |
| | Cranbrook (Foundry East Kootney) | Ktunaxa-Kinbasket Child & Family Services | Interior | *By 2022/23* |
| | Langley | Encompass Support Services Society | Fraser | *By 2022/23* |
| | Squamish (Foundry Sea to Sky) | Sea to Sky Community Services Society | Vancouver Coastal | *By 2022/23* |
| | Surrey | Pacific Community Resources Society | Fraser | *By 2022/23* |
| | Port Hardy | North Island Crisis & Counselling Centre Society | Island | *By 2022/23* |
| | Williams Lake (Foundry Cariboo-Chilcotin) | Cariboo Chilcotin Child Development Centre | Interior | *By 2022/23* |

## FINANCIAL IMPLICATIONS

The following funding has been provided or allocated for Foundry from 2014/15 to 2020/21:

- In 2014/15, the Ministry provided $3.0 million to the InnerChange Foundation to support the development and implementation of the 5 initial Foundry centres over 3 years.
- In 2016/17, the Ministry provided $2.5 million in base funding to the regional health authorities (RHAs) for the operations of the initial 5 Foundry centres.
- In 2017/18, the Ministry provided St. Paul's Foundation $1.5 million and $1 million in base funding to the RHAs for Foundry centre expansion and operations. The Ministry also established an agreement of up to $1.8 million with PHC to support FCO.
- In 2018/19, the Ministry provided an additional $2.9 million in base funding to the RHAs for Foundry local centres and $2.9 million to PHC for FCO.
- In 2019/20, the Ministry provided an additional $1.3 million in base funding to RHAs for the Foundry expansion and allocated up to $4.04 million to PHC for FCO.
- In 2020/21 the Ministry's total base funding allocation to the RHAs for Foundry Centres is $7.7 million and $8.46 million has been allocated to PHC, through a shared cost agreement, for FCO. Of the $8.46 million: $4.435 million was approved in a 2019/20 Contract Issue Note as part of *Pathway* funding commitments; $0.925 million in COVID-19 responding funding for Foundry virtual care workforce; and $3.1 million to support the implementation of the 8 new Phase 3 centres.
- Budget 2021 provides $97 million over three years to provide targeted mental health supports for children, youth and young adults which includes funding to support opening four additional Foundry centres, for a total of 23 province-wide.

[6] Foundry Central Office. (January 2021). Foundry Quarterly Report. Reporting Period: October 1, 2020 – December 31, 2020.
[7] Foundry Richmond open in interim physical site, with plans to relocate to a permanent location in 2021: https://foundrybc.ca/location_news/foundry-richmond-has-a-physical-interim-site/
[8] Foundry Terrace open in interim physical site and is slowly increasing service offerings: https://foundrybc.ca/terrace

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
February 17, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
April 27, 2021 – Ross Hayward obo Teri Collins, ADM, Health Services Division
May 5, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Gastrointestinal Endoscopy – Colonoscopy Strategy

### TOPIC

In December 2020, government renewed their commitment to provide faster care, so patients will have shorter wait times for the care they need.

### CURRENT SITUATION

- For 2021/22, the focus continues on increasing capacity and reducing wait times for all GI endoscopies through a variety of strategies, including: improving waitlist management, increasing operating capacity and efficiency, developing a coordinated single-entry model, developing best practices for health human resources, and continuing to make data improvements for standardized data collection and reporting.
- As part of the provincial COVID pandemic response, the Ministry of Health directed health authorities to postpone all non-urgent health services, including GI endoscopies between mid-March to mid-May. As per the directive from the Ministry, urgent GI endoscopies continued to be performed. It is estimated this resulted in loss of 20,993 colonoscopies and 7,660 other GI endoscopies during an 10-week period (Period 13 - 02).[1]
- As part of the provincial response to COVID-19, distribution and testing of FIT kits was briefly suspended in mid-March 2020. FIT testing resumed on June 8, 2020 and volumes are currently above historical benchmarks.[2]
- These services have now resumed, and health authorities are working on increasing capacity to move through the backlog of postponed patients.

### KEY FACTS

Background

- GI endoscopies are a vital screening, diagnostic and treatment services for patients.
- GI endoscopies are non-surgical procedures that inserts an endoscope, which is a fiber-optic tube with a miniature camera at the end, to view the inside lining of the gastrointestinal tract.
- These procedures are usually performed by gastroenterologists, general surgeons, and sometimes by general practitioners in an endoscopy suite/procedure room or operating room.
- The most common type of GI endoscopy is a colonoscopy, in which a patient is referred for:
    - **Screening purposes:** where a patient is asymptomatic (no symptoms) but has been identified through a positive FIT as needing further investigation or who have a significant family history of colon cancer or a personal history of adenoma(s).
    - **Diagnostic purposes:** where a patient has symptoms and their physician has identified them as requiring further care or investigation.

Volumes (see Table 1)[3]

- In 2020/21:
    - 119,073 scheduled colonoscopies were performed, a decrease of 20,137 (-14.5%) from the year before.
    - 47,569 scheduled other GI endoscopies were performed, a decrease of 5,640 (-10.6%) from the year before.
- Prior to the onset of the COVID pandemic, significant progress had been made in the volume of colonoscopy and all other GI procedures performed. Colonoscopy procedures increased by 20,694 procedures in 2019/20 compared to 2016/17.

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[1] Health Sector Information Analysis and Reporting Division, Ministry of Health. Colonoscopy / GI Endoscopy Period Report 2019/20 as reported at P13 and Colonoscopy / GI Endoscopy Period Report 2020/21 as reported at P13. Calculated by comparing 2019/20 P12 actuals multiplied by 3 to the sum of 2019/20 P13 to 2020/21 P02 actuals.

[2] For more information, see the Fact Sheet on Colon Screening Program and Fecal Immunochemical Test (FIT) Platform

[3] Health Sector Information Analysis and Reporting Division, Ministry of Health. Priority Wait Times Locked-in Numbers

# LEGISLATIVE SESSION - FACT SHEET

Table 1. Scheduled Colonoscopy and Other GI Endoscopy Volumes 2016/17 – 2019/20

| HA | Procedure Type | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | Colonoscopy 16/17 to 20/21<br>Other GI 18/19 to 20/21 | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | # change | % change |
| IHA | Colonoscopies | 23,690 | 25,227 | 31,363 | 28,330 | 24,609 | 919 | 3.90% |
| | Other GI Endos | - | - | 11,320 | 11,996 | 12,253 | 933 | 8.20% |
| FHA | Colonoscopies | 35,215 | 34,979 | 41,346 | 43,489 | 37,148 | 1,933 | 5.50% |
| | Other GI Endos | - | - | 14,424 | 14,725 | 13,554 | -870 | -6.00% |
| VCHA | Colonoscopies | 32,002 | 30,113 | 32,076 | 32,431 | 27,887 | -4,115 | -12.90% |
| | Other GI Endos | - | - | 12,084 | 12,111 | 10,854 | -1,230 | -10.20% |
| VIHA | Colonoscopies | 19,282 | 22,449 | 25,350 | 26,822 | 23,385 | 4,103 | 21.30% |
| | Other GI Endos | - | - | 10,459 | 10,865 | 8,433 | -2,026 | -19.40% |
| NHA | Colonoscopies | 8,327 | 8,200 | 8,824 | 8,138 | 6,044 | -2,283 | -27.40% |
| | Other GI Endos | - | - | 3,298 | 3,512 | 2,475 | -823 | -25.00% |
| **BC – TOTAL** | **Colonoscopies** | **118,516** | **120,968** | **138,959** | **139,210** | **119,073** | **557** | **0.50%** |
| | **Other GI Endos** | **-** | **-** | **51,585** | **53,209** | **47,569** | **-4,016** | **-7.80%** |

Wait Times (see Table 2)[4]

- In 2020/21 Period 13, there were 29,024 patients waiting for a colonoscopy in BC, which is an increase of 1,874 from Period 01.
- In 2020/21 Period 13, there were 9,711 patients waiting for an other GI endoscopy in BC, which is an increase of 746 from Period 01.

Table 2. Scheduled Colonoscopy and Other GI Endoscopy Wait Times 2020/21, Period 01 and 13

| HA | Procedure Type | Cases Waiting | | % > Benchmark | | 50th Percentile (Weeks) | | 90th Percentile (Weeks) | |
|---|---|---|---|---|---|---|---|---|---|
| | | P01 | P13 | P01 | P13 | P01 | P13 | P01 | P13 |
| IHA | Colonoscopies | 3,803 | 3,768 | 32.1% | 16.8% | 9.7 | 4.1 | 27.7 | 20.4 |
| | Other GI Endos | 1,578 | 1,684 | 42.8% | 23.1% | 9.4 | 3.9 | 24.7 | 22.4 |
| FHA | Colonoscopies | 8,326 | 8,808 | 53.2% | 50.0% | 14.6 | 15.9 | 53.4 | 79.2 |
| | Other GI Endos | 2,671 | 2,876 | 59.8% | 57.2% | 13.6 | 17.0 | 50.6 | 82.0 |
| VCHA | Colonoscopies | 8,013 | 9,811 | 54.9% | 51.5% | 16.3 | 17.4 | 60.3 | 73.7 |
| | Other GI Endos | 2,302 | 3,128 | 64.8% | 54.2% | 19.4 | 16.7 | 66.0 | 70.9 |
| VIHA | Colonoscopies | 6,026 | 5,656 | 29.2% | 19.1% | 8.0 | 5.3 | 47.7 | 27.9 |
| | Other GI Endos | 1,990 | 1,503 | 32.2% | 34.8% | 8.9 | 6.7 | 45.2 | 40.7 |
| NHA | Colonoscopies | 982 | 981 | 36.9% | 27.3% | 8.1 | 4.8 | 28.2 | 25.0 |
| | Other GI Endos | 424 | 520 | - | - | 9.3 | 6.8 | 49.2 | 61.6 |
| **BC – TOTAL** | **Colonoscopies** | **27,150** | **29,024** | **44.8%** | **39.4%** | - | - | - | - |
| | **Other GI Endos** | **8,965** | **9,711** | **51.5%** | **46.2%** | - | - | - | - |

## FINANCIAL IMPLICATIONS

The Ministry allocated up to $175 million in targeted operational funding for the Strategy in 2020/21. Up to approximately $10 million from within the $175 million supporting the Strategy was available to health authorities for colonoscopies in 2020/21.

**Approved:**

February 15, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
February 16, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
May 7, 2021 – Teri Collins, ADM, Health Services Division
May 14, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

[4] Health Sector Information Analysis and Reporting Division, Ministry of Health. Colonoscopy / GI Endoscopy Period Report 2020/21 as reported at P13

# LEGISLATIVE SESSION - FACT SHEET

## Healthy Aging – Community Based Seniors Services

### TOPIC

- The Ministry of Health's investment in healthy aging programming, provided through community-based seniors' services (CBSS) organizations, aligns with the BC government's commitment towards coordinated and integrated care that supports seniors to live independently in the community, at home, for as long as possible.[1]
- CBSS organizations include seniors' centres, neighborhood houses, community centres, community coalitions, ethno-cultural organizations and multi-service non-profit agencies.

### CURRENT SITUATION

- In response to COVID-19, the Safe Seniors, Strong Communities initiative began as a collaboration between the Ministry of Health, bc211, United Way of the Lower Mainland (UWLM), The Office of the Seniors Advocate, and 24 hub agencies throughout the Province to provide non-medical supports to seniors (see Safe Seniors Strong Communities fact sheet).
- The Integrated Community-Based Programs for Older Adults with Higher Needs (Higher Needs) grant program that targets services for older adults with higher needs and their respective caregivers has been impacted by COVID-19 through delayed program start dates and shifting program delivery models for participant safety. The Therapeutic Activation Program for Seniors (TAPS) and Social Prescribing program were most impacted due to their intended in-person service delivery model; some agencies were able to pivot to deliver services online. Additionally, many of the agencies shifted to support the Safe Seniors, Strong Communities program. Service delivery of Higher Needs is now incrementally increasing across programs.
- Expansion of the Higher Needs program is underway: Advice/Recommentations

Advice/Recommentations

### KEY FACTS

- Approximately 4%[2] of British Columbians age 65+ resided in a long-term care facility or assisted living facility, meaning most seniors live independently in the community.
- In 2017/18, the Ministry worked with the UWLM regarding provincial coordination of the CBSS sector. The UWLM established a knowledge hub of resource materials, training and supports, and communities of practice, where participants can share information and stories, ask questions, learn and collaborate. Healthy Aging CORE (https://bc.healthyagingcore.ca/ ) was launched in February 2019 and is now a key support for agencies providing services to seniors, including during COVID-19.
- The Raising the Profile project,[3] led by the UWLM with support from the Ministry, found the following:
  - CBSS programs and services that help older adults to remain physically and mentally active, socially connected and resilient have significant health benefits; and,
  - nutrition, physical activity and social support are 3 areas in which community-based services may substantially impact the health and well-being of seniors and reduce the use and cost of healthcare services.
- Higher Needs grant funding supports 65 demonstration projects in all health regions across 4 streams[4]:
  - **Stream One: The Therapeutic Activation Program for Seniors (TAPS)** is modelled after a 10-year running program developed in Creston. The program provides proactive outreach through daily/weekly telephone calls to approximately 60 participants per community, transportation to and from the program, nutritious meals, exercise programs and recreational/educational activities that meet the

[1] Ministry of Health 2020/21-2022/23 Service Plan, p. 7.
[2] Community and Cross Sector Branch; Health Sector Information Analysis and Reporting Division, Ministry of Health. (2020)
[3] Kadowaki, Laura and Cohen, Marcy, Raising the Profile of the Community-based Seniors' Services Sector in B.C.: A Review of the Literature. March 2017 http://www.seniorsraisingtheprofile.ca/about-the-sector/research-report/.
[4] United Way of the Lower Mainland email correspondence, April 25, 2021.

specific needs of the community. The 16 organizations that have received funding to run this program are in the following communities: Fraser Health—Burnaby and Surrey; Vancouver Coastal—Vancouver (4 programs), North Vancouver and Powell River; Northern Health—Fraser Lake; Island Health—Nanaimo and Hornby Island; and Interior Health—Lumby, Creston, Oliver, Alkali Lake and Kaslo.

- **Stream Two: The Family & Friend Caregiver Support program** is supported by Family Caregivers of BC to support caregivers of older adults with complex needs by providing peer-supports, coaching, counselling and education. The 17 organizations that have received funding to host a program are in the following communities: Northern Health—Terrace and Prince George; Fraser Health—Burnaby, Pitt Meadows, Surrey and Abbotsford; Interior Health—Cranbrook, Lake Country, Nelson and Penticton; Vancouver Coastal—Vancouver (3 programs), Richmond and North Vancouver; and Island Health—Duncan and Sidney.
- **Stream Three: The Social Prescribing program** pairs seniors at risk of frailty with a community navigator who creates an individualized wellness plan that connects the senior to community-based services that best fit their needs and preferences. These may include physical activity programs, nutrition/food security programs, social programs/services, or caregiver programs. Piloted in White Rock and Maple Ridge, the program is being implemented throughout 9 communities in Fraser Health, and 10 more in other regions throughout BC. Fraser Health communities are as follows: Mission, Delta, Surrey (3 programs), Burnaby, Coquitlam, Chilliwack, and Maple Ridge. Other RHA communities are as follows: Vancouver Coastal—Vancouver (4 programs) and North Vancouver; Northern Health—Dawson Creek; Interior Health—Invermere and Kelowna; and Island Health—Gabriola Island and Cowichan Valley.
- **Stream Four: The Navigation and Peer Support program** helps vulnerable seniors from underserved populations access the local, provincial, and federal benefits they need to remain healthy and independent. The 13 organizations that have received funding to host a program are in the following communities: Fraser Health – Chilliwack, Maple Ridge and Abbotsford; Interior Health – Nelson and Penticton; Northern Health – Fraser Lake; Vancouver Coastal – Vancouver (4 programs); and Island Health – Victoria (2 programs) and Courtenay.

- Men's Sheds provide a safe, friendly, and inclusive environment for men to gather and participate in group activities. UWLM reports that over 90% of older adults accessing CBSS programming are women. Men's Sheds aim to create a community environment that appeals specifically to men to increase their engagement. Details of program roll out are under development by UWLM.

## FINANCIAL IMPLICATIONS

Government Financial Information

- In 2019/20, the Ministry provided Government ($50 million announced, Government Financial Informationfor the UWLM programming.Government Financial Information

Government Financial Information

**Approved:**
February 26, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
April 19, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
May 7, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Home Health

### TOPIC

BC has a comprehensive range of home health (HH) services, including community-based professional services (CBPS), home support (HS), adult day programs (ADP), respite, and at home end-of-life care. These services support seniors as well as people with disabilities of all ages, to manage their health care needs and remain living at home in their community.

### CURRENT SITUATION

Health authorities have adjusted the delivery of home health services in response to the COVID-19 pandemic. More services are being delivered virtually, work has been undertaken to reduce the number of workers visiting each client, and there have been temporary suspensions of adult day program and respite services to reduce transmission of COVID-19. (X-Ref COVID-19 Response for Clients in Community)

**Community Based Professional Services (CBPS)**

In 2020/21, approximately 132,000 British Columbians received CBPS, a 14% increase from 2016/17. This represents approximately 1,716,000 CBPS visits (24% increase over 2016/17).[1]

**Home Support (HS) Services**

- In 2020/21, approximately 50,000 British Columbians received HS (a 1% increase over 2016/17 baseline, a 4% decrease from 2019/20), helping them remain as independent as possible, and providing respite for caregivers. This represents approximately 11,087,000 hours, which was a 2% increase over 2016/17, and a small decrease from the approximately 11,341,000 hours delivered in 2019/20, which is not unexpected due to COVID-19 impacts.[1]
- COVID-19 impacts on home support include clients cancelling visits, staff shortages due to illness/ self-isolation and re-deployment of home support staff to support outbreaks in long term care. In this same timeframe, seniors were supported with additional services through the "Safe Seniors, Strong Communities Program" (see separate fact sheet).

**Home Support Transition** (X-Reference Home Support Transition Fact Sheet)

Vancouver Coastal (VCHA), Fraser (FHA) and Vancouver Island Health Authorities (VIHA) have completed the repatriation of home support services from contracted service providers. In total, over 4,000 staff and 12,000 clients transitioned from contracted service providers to services provided by health authority staff.[2]

### KEY FACTS

- Premier Horgan's November 26, 2020 mandate letter to Minister Dix calls to: *'improve and expand publicly funded home care to provide better care and help with daily living so that people can stay in their own homes for as long as is safely possible, receiving care from a more stable group of care aides'*.
- Policy development is underway to achieve the mandate commitment, including:Advice/Recommentations Advice/Recommentations Advice/R increasing the number of care aids (Health Career Access Program);Advice/Recommentations Advice/Recommentations Advice/Re in addition to the temporary COVID-19 response policies already in place for Expanded In-Home Respite and Non-Clinical Support Workers (see COVID Response for Clients in Community Fact Sheet).
- A key component of the Ministry of Health's approach to home health is the implementation of Specialized Community Service Programs in the health authorities, which will improve the integration of home health with other primary care and community-based services and achieve improved home health quality attributes.

**Community Based Professional Services**

CBPS are provided by regulated health care professionals and include nursing, rehabilitation (occupational and physical therapy), and social work services. CBPS include assessment, care planning, care provision, and active case management, with emphasis on early intervention, post hospital discharge and prevention of readmission

[1] Home and Community Care Progress Report 2020/21 P13 Draft_0519 HS Updated

[2] Seniors Strategic Investments Year End Report 2019/20 and communication with VCH

through linkages with primary care networks, and active case monitoring to support people to live independently in the community.

**Home Support Services**

- Home support (HS) services are provided by unregulated care providers (Health Care Assistants / 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 (i.e. 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 home support clients to enable independent living for as long as possible, and also for short-term home support clients, i.e. following hospital discharge.
- 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 (see CSIL Fact Sheet), a self-directed option for clients with high-intensity care needs.

**Home Support Transition** (X-Reference Home Support Transition Fact Sheet)

- VCHA, FHA, and VIHA have completed the repatriation of home support services from contracted service providers. These services will now be provided by health authority staff.
- VCHA and FHA opted to not renew provider's contracts when audits raised contractual compliance and communication concerns. VIHA and its contracted service provider for the Southern Vancouver and Gulf Islands agreed to transition services to VIHA due to difficulties experienced in meeting service demands.
- Having home support services delivered by in-house staff better enables health authorities to plan, deliver, and integrate all services directly, leading to a more coordinated and connected community and primary care system, and improves accountability and continuity of care for clients.

**Office of the Seniors Advocate (OSA): Home Support Review Report**

- On June 19, 2019, the OSA released a report on HS services with the following recommendations:
  1. Remove financial barriers tied to the regulated daily rate co-payment.
  2. 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 and just-in-time needs of the client.
  3. Examine the role of Care Managers and determine if current resources are adequate.
  4. 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.
  5. 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.
  6. Develop a program for client direct funding that is flexible and accessible.
  7. The HAs work collectively through HEABC to examine incentives to successfully recruit and retain CHWs.
- The OSA's recommendations strongly align with work underway at the Ministry and are informing ongoing policy development to improve and expand home health services.

## FINANCIAL IMPLICATIONS

- Budget 2021 provides roughly $68M over the 3 years of the fiscal plan ($22.67M annually, flat-lined) to increase support for home care services, including increasing care aides and community providers. In addition, $12M over 3 years is also provided for the Home Health Monitoring Initiative which supports patients to self-manage their health from the comfort of their homes.
- In 2019/20, HAs reported spending more than $1.4B on community care services, including adult day services, professional services (nursing and rehabilitation), home support, case management and assisted living services.
- The Ministry is investing $75M over 3 years to expand respite care and adult day programs, helping both seniors and their loved ones.

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division
May 25, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
May 27, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Home Support Transition

### TOPIC

- Vancouver Coastal Health Authority (VCH), Fraser Health Authority (FHA), and Vancouver Island Health Authority (VIHA) have completed the repatriation of home support services from contracted service providers. These services will now be provided by health authority staff.
- Having home support services delivered by in-house staff better enables the health authorities to plan, deliver, and integrate all services directly, leading to a more coordinated and connected community and primary care system, and improves accountability and continuity of care for clients.

### CURRENT SITUATION

- All planned home support transitions have been successfully completed:
  - Between October 2019 and April 2020, 14 out of 15 transitions were completed, repatriating services from 5 providers and completing all transitions within VIHA and FHA.
  - The final VCH transition, originally scheduled for April 28, 2020, was rescheduled due to COVID-19 and completed September 29, 2020.
- Across all transitions, over 4,000 staff and 12,000 clients transitioned from contracted service providers to services provided by health authority staff.[1]
- The transition of home support services supports the Ministry's priority to improve the integration of primary and community care by enhancing service coordination and accountability.
- Health authorities may utilize contracted services on an exceptional basis to intermittently bridge service gaps during times of overcapacity.

### KEY FACTS

- The repatriation of home support services for VCH and FHA was influenced by audits of the contracted providers that revealed contractual compliance and communications irregularities. The decision was made to not renew the providers' contracts.
- VIHA and Beacon Community Services (BCS), the non-profit contracted service provider for home support services on Southern Vancouver Island and the Gulf Islands, agreed to transition services to VIHA due to difficulties experienced by BCS in meeting service demands. Prior to this transition, VIHA provided home support services for North/Central Island.
- Formerly, VCH and FHA contracted with a total of 5 different service providers, 3 of which provided services to both HAs. VIHA employed only BCS. In total, the transition of home support services across the 3 health authorities entailed 15 discrete transition milestone events.
- The Ministry contracted former Associate Deputy Minister Lynn Stevenson to oversee the repatriation of services and identified 5 principles to guide transition activities:
  - Minimal disruption to clients and staff;
  - Consistency of client costs (variances to be covered by health authorities);
  - Comparable positions for included and excluded staff;
  - Efficiency; and
  - Stability.
- During the first week of service following each transition, approximately 96,000 visits and 72,000 hours of service were provided.
- In addition to near complete retention of staff (i.e., staff of contracted service providers transitioned to become health authority staff), over 250 positions were converted from casual to regular status in the initial transition.
- Minimizing disruption to clients through the transition was measured through the rate of missed visits. In the first week of service following transitions, VIHA had 0 missed visits and VCH had 4 missed visits., or 0.02% of total visits missed. FHA had 1.29% of visits missed and this reduces to 0.25% when cancellations

[1] Seniors Strategic Investments Year End Report 2019/20 and communication with VCH

due to an extreme weather event are excluded (heavy snowfall occurred on Day 1 of a transition in Surrey, which resulted in 73% of visits cancelled – a rate consistent with non-transition service areas).

- With the repatriation of home support services, utilization of Procura software for coordination and scheduling of home support services improves capacity for regional and provincial roll-up and analysis of data system-wide to enable continuous quality improvement.
    - VIHA has seen a significant improvement in their staff retention rate since the transition from BCS and the switch to a neighbourhood cluster service delivery model. In this model, individuals work within a set geographic area, improving staff efficiency and enabling them to more freely adapt to the changing needs of their clients.
- Health authorities are closely monitoring the continuity of community healthcare workers supporting clients, recognizing this is one of several important factors that influence client satisfaction with their home support service. Health authorities are actively engaged with clients and staff to continuously improve program delivery post transition and for home support overall.

## FINANCIAL IMPLICATIONS

FHA reported the following:

- There were no external providers' costs in 2019/20.
- FHAs incremental 2019/20 operating costs were $4.3 million primarily related to:
    - Project Leadership and Consulting
    - Legal Fees
    - Payroll/Accounts Receivable
    - Employee Engagement
    - Clinical Programming
    - Staff Orientation
- FHAs incremental 2019/20 capital costs were $2.4 million and are estimated to be $0.498 million in 2020/21.

VCHA reported the following:

- External providers' 2019/20 costs were $0.025 million and are estimated to be $0.915 million in 2020/21.
- VCHAs incremental 2019/20 operating costs were $4.6 million primarily related to:
    - Project Leadership and Consulting
    - Payroll/Accounts Receivable
    - Procura Mobile IMITS/Procura Repatriation/Licensing
    - Employee Engagement
    - HR Project Resources
    - Regional Project Team
- VCHAs incremental 2020/21 operating costs are estimated to be $3.1 million.
- VCHAs incremental 2019/20 capital costs were $0.616 million and are estimated to be $0.417 million in 2020/21.

VIHA reported the following:

- External providers' 2019/20 costs were $0.834 million.
- VIHAs incremental 2019/20 operating costs were $2.5 million primarily related to:
    - Regional Transition Team
    - Bad debt from taking on client receivables.
- VIHAs incremental 2020/21 operating costs are estimated to be $0.754 million.
- VIHAs incremental 2019/20 capital costs were $0.391 million.

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**Approved:**

February 15, 2021 – Teri Collins, ADM, Health Services Division

April 15, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Homelessness and Encampment Response

### TOPIC

- More than 7,655 people experience homelessness in BC, based on the most recent Provincial point in time homelessness count conducted in 2018.[1]
- In 2020, more than 2,500 people in homelessness encampments in communities were tracked through ministry requests across the Province. This is a significant increase from 2018 and 2019[2].
- Many people experiencing homelessness are living with complex health issues, including chronic disease, mental health or substance use issues, and injuries or physical disability, and life expectancy for people experiencing homelessness is lower than the general population.[3] Other determinants of health are also key drivers of homelessness including poverty and lack or loss of housing. Ministries are working collaboratively to respond to emergent issues and to provide coordinated services for people experiencing homelessness, including those living in encampments across the province.

### CURRENT SITUATION

- Homelessness has been increasing in BC.[1] Homelessness disproportionately impacts Indigenous people, and many experiencing homelessness are living with multiple and complex health issues.
- The COVID-19 pandemic has highlighted critical needs for people experiencing homelessness and those living in encampments. Many may be living with complex health issues and could be at a greater risk if exposed to COVID-19. Many may not be able to maintain safe physical distance or isolate if experiencing COVID-19 symptoms.
- Many services for people experiencing homelessness such as shelters, drop-in centres, and meal programs, were reduced due to risk of COVID-19 transmission, and even where services remain available, people may be reluctant to access them. These factors have contributed to an increase in visible/street homelessness.
- In response to COVID-19, the Province secured temporary spaces in hotels, motels and community centres across BC to support individuals to physically distance and self-isolate to prevent the spread of COVID-19. As of March 12, 2021, BC Housing has secured 2,806 spaces across 126 sites.[4] Enhanced screening and cleaning protocols are in place at residential facilities to prevent the spread of the virus.
- The Province has developed a *COVID-19: Joint Provincial Program Framework for Emergency Response Centres* (ERCs), which details operating principles, referral pathways, and roles of health and housing partners in supporting those that are experiencing homelessness to reduce transmission of COVID-19.
- In response to COVID-19, health authorities and partners in some communities throughout BC have implemented new health services to support those experiencing homelessness or living in encampments, including:
    - Implementing mobile and fixed site COVID-19 testing and specialized contact tracing services for vulnerable populations
    - New outreach services, including outreach teams that respond to vulnerable populations and provide clinical supports to those isolating in supportive housing or shelters due to COVID-19
    - ERC clinical in-reach, where health care providers attend to individuals that have transitioned indoors to physically isolate
- On April 25, 2020, the Minister of Public Safety and Solicitor General ordered the evacuation of encampments at Oppenheimer Park in Vancouver and Topaz Park and Pandora Corridor in Victoria.[5] The Province led a collaborative effort in partnership with municipalities and health and housing partners, to rapidly provide temporary accommodation and wrap-around services for those living in these

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[1] Homelessness Services Association of BC, Urban Matters and BC Non-profit Housing Association. 2018 Report on Homeless Counts in BC. Burnaby, BC: Metro Vancouver. Retrieved from: www.bchousing.org

[2] Email communication from Homelessness Policy and Partnerships Branch, Ministry of Attorney General. Feb. 12, 2021

[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

[4] BC Housing. Jan 21, 2021. Community self-isolation sites & shelter expansion. Retrieved from: https://www.bchousing.org/COVID-19/community-sites

[5] Province of British Columbia. April 24, 2020. Ministerial Order No. M128. Retrieved from: https://news.gov.bc.ca/files/M128-2020.pdf

3 encampments. 605 people from across 3 sites were transitioned indoors, primarily to hotels leased or purchased by BC Housing. 90 to 95 % remain stably housed.

- In September 2020, the Province announced funding for 6 new Assertive Community Treatment (ACT) teams to provide outreach, comprehensive care and support to people with severe mental health issues[6]. In partnership with health authorities, funding was used to create a total of 9 teams (3 more than announced), as well as to strengthen and enhance existing teams. New teams are located in Quesnel, Kelowna, Burnaby, Maple Ridge, Vancouver, Richmond, Victoria, Cowichan Valley and Comox, with implementation well underway. Individuals who meet the ACT admission criteria and who are in a homeless encampment site or at risk of homeless will be given priority access to the new ACT teams. These teams are mobile and deliver 24/7 services throughout the community, including in supportive housing or encampments.
- As of April 2021, there are several major encampments in BC, including encampments in Victoria, Vancouver, Central Vancouver Island, the Fraser Valley, and the BC interior, as well as numerous small, scattered encampments in rural and urban areas.
- The Province has signed memorandums of understanding (MOUs) with both the City of Victoria and the City of Vancouver that formalizes a commitment to end current homeless encampments and to help prevent encampments in the future. This MOU clarifies the roles and responsibilities of the Province and city in securing accommodation for people currently living outside to decamp parks and other public spaces in Spring 2021.[7]
- As of April 2021, the Province and BC Housing have secured more than 300 additional housing and shelter spaces across numerous sites in Vancouver and Victoria. Opening dates range from March – June 2021.
- Vancouver Coastal and Vancouver Island Health Authorities are working closely with BC Housing and the Province to ensure all individuals moving from encampments into indoor spaces have access to necessary health services, including harm reduction and overdose prevention, primary care, and mental health and substance use supports (see attached).

## KEY FACTS

- Key priorities from 2020 Ministry of Health (HLTH) mandate letter:
  - Support the work of the Minister of Mental Health and Addictions to improve BC's response to the opioid crisis across the full continuum of care.
  - Support the work of the Minister of Mental Health and Addictions to provide an increased level of support for BC's most vulnerable by developing Complex Care Housing.
  - Support the work of the Attorney General and Minister responsible for Housing to address the needs of people experiencing homelessness, including those living in encampments.
- The Ministry of Health, working with partner ministries, BC Housing, and health authorities, is exploring cross-sector policy options and approaches to support people with mental health or substance use issues that are transitioning from homelessness to supportive housing.

## FINANCIAL IMPLICATIONS

- Budget 2021 provides $152 million for opioid treatment over the fiscal plan which includes additional support for ACT teams.
- In 2020/21, the Ministry provided funding of $2.236 million to Vancouver Coastal Health Authority and $9.360 million to Vancouver Island Health Authority to reimburse costs incurred to support the decampment initiatives related to Oppenheimer Park and Pandora Avenue.
- In 2020/21, the Ministry provided the regional health authorities up to $8.0 million to begin implementing 6 additional ACT teams. Funding was used to create a total of nine new ACT teams.

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**Approved:**
April 26, 2021 - Teri Collins, ADM, Health Services Division
May 5, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

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[6] BC Gov News. September 2020. More mental health supports to help vulnerable people, communities. Retrieved from: https://news.gov.bc.ca/releases/2020MMHA0052-001819

[7] BC Gov New. Province, City of Victoria sign agreement to end encampments. March 2021. Retrieved from https://news.gov.bc.ca/releases/2021AG0022-000521

# LEGISLATIVE SESSION - FACT SHEET

# Hospital at Home BC Prototype

## TOPIC

The Ministry of Health has launched a prototype Hospital at Home program in BC, aimed at increasing hospital capacity by providing acute care to patients in their homes.

## CURRENT SITUATION

- In February 2020, Island Health submitted a request to the Ministry of Health to partner in the development of a prototype for a Hospital at Home (HaH) program.
- The BC COVID-19 Go-Forward Management Strategy identified the HaH program as a core health system mechanism for the "new normal" in response to COVID-19 and committed to rolling out the model provincially by winter 2020/21.[1]
- The commitment to HaH was further strengthened in the Health Sector Plan for Fall/Winter 2020-2021 Management of COVID-19 released on September 9, 2020.[2]
- In December 2020, the Speech from the Throne noted: "A new Hospital at Home initiative is ramping up across the province that allows patients to receive medical services in their own home, helping to reduce congestion in hospitals." [3]
- A 9-bed prototype launched at the Victoria General Hospital, Island Health in November 2020, followed by a second 9-bed prototype at the Royal Jubilee Hospital in March 2021. Northern Health also launched a 9-bed prototype at University Hospital of Northern BC which from ran from mid-March 2021 to mid-May 2021.
- Further program expansion will be considered following evaluation of the prototype sites.

## KEY FACTS

- The HaH program provides acute care to patients in their own home. Eligible patients requiring hospital care are admitted to hospital but receive care at home from an interdisciplinary team led by a most responsible practitioner (physician) with hospital admitting privileges.
- HaH will allow a subset of acutely ill, clinically stable patients to choose an alternative to traditional in-patient treatment that is still safe, respectful and effective.
- Patients admitted to HaH are considered inpatients and receive daily in-person care supplemented by virtual care and monitoring. Patients and caregivers will have 24/7 access to care and supports, including scheduled and unscheduled in-person visits from physicians and nurses.
- Because they have not been discharged from hospital to be at home, a HaH patient can be transferred directly back to the hospital, if needed, without having to go through the emergency department. Access to medically necessary general hospital services and resources, such as diagnostics and medications are available in the same timely manner as in a traditional "bricks and mortar" hospital.

**HaH in other Jurisdictions**

- HaH programs have been in place in other jurisdictions for many years. For example, Australia has had a HaH program since the 1990s and is one of the most mature programs internationally. In the Australian state of Victoria, HaH has added to hospital capacity and resulted in the addition of about 500 hospital beds.[4]
- The United Kingdom, Wales and Ireland, the Veterans Affairs system in the United States and New Zealand have all implemented versions of HaH. A small HaH pilot was recently completed in Toronto with lessons shared. Alberta has a small HaH program for pediatric oncology.

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[1] "*BC COVID-19 Go-Forward Management Strategy*." p. 19. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/bc_covid-19_go-forward_management_strategy_web.pdf Accessed: 09 June 2020

[2] *"Management of COVID-19: Health Sector Plan for Fall/Winter 2020/21."* https://news.gov.bc.ca/files/COVID-19_fall-winter_preparation.pdf

[3] "*Speech from the Throne."* https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/42nd-parliament/1st-session/throne-speech. December 7, 2020. Accessed 09 February 2021.

[4] Montalto, M. "The 500-bed hospital that isn't there: the Victoria Department of Health review of the Hospital in the Home Program. Med J Aust 2010; 193 (10): 598-601. || doi: 10.5694/j.1326-5377.2010.tb04070.x https://www.mja.com.au/journal/2010/193/10/500-bed-hospital-isnt-there-victorian-department-health-review-hospital-home

**Benefits of Hospital at Home**

- Several Cochrane reviews, which represent the highest standard in meta-analysis, report the HaH model has fewer complications compared to traditional hospitalizations such as fewer instances of delirium, blood clots, infection and functional decline.[5,6]
- Other benefits may include shorter length of stay, lower readmission rates, high levels of patient/ caregiver satisfaction, and potentially fewer admissions to long-term care.From a system perspective, by creating an additional pathway to access acute care, HaH will improve access and increase efficiency through reducing pressure on traditional in-patient hospitals beds, decreasing hospital congestion by optimizing patient flow, and improving overall system capacity.
- Participation in HaH is entirely voluntary and patients and caregivers can choose to return to hospital at any time. HaH patients can choose to stay in a familiar environment, stay active and mobile, and avoid exposure to infectious illnesses, including COVID-19.

**BC Hospital at Home Prototypes and Evaluation**

- Prototype Sites - As of June 2021, 18 HaH acute care beds are in operation. Northern Health had 9 beds in operation from mid-March to mid-May 2021.
- Evaluation – The prototype sites will be evaluated prior expansion to additional sites. An evaluation will provide an opportunity to refine the program and supporting infrastructure (such as technology and compensation frameworks) prior to further implementation.
- Physician Services - The prototypes take a different approach to providing physician services. HaH physician services at the Island Health prototype sites are provided by hospital-based physicians working exclusively on HaH for the duration of their shift, whereas the Northern prototype relied on community-based physicians with hospital-admitting privileges who will provide HaH as part of their family practice.
- Interim Provincial Policy - An interim HaH policy has been developed to guide planning and implementation. This policy will be updated, as needed, based on local experience and consultation.
- Team-based Care - During the prototype phase care teams will be smaller (for example physicians, nurses and pharmacists). Information gathered from the prototypes will further inform the staffing model, but it is expected that the interdisciplinary care teams will likely have a similar composition, clinical skills and knowledge to the team that would provide care if the patient were physically present at the hospital.
- Virtual Care - HaH relies primarily on in-person care, supplemented by virtual appointments and monitoring.

**Population Eligibility Criteria**

HaH will assist adult patients to return to health and receive acute care in a manner that minimizes disruption to their lives. Rather than a focus on serving patients with specific illnesses, the BC approach will focus on demographic and clinical characteristics and rely on a clearly defined referral process and eligibility criteria that emphasizes predictable clinical course and short-term nature of admission. This makes the program accessible to a broader range of patients while promoting safety. For example, eligibility criteria include: adult; lives within a defined geographic catchment area from the hospital; consenting caregiver in the home for the duration of the admission; known diagnosis; requires acute care but is clinically stable; time needed for treatment is expected to be under seven days; and, unlikely to require multiple in-hospital tests, treatments or consultations.

## FINANCIAL IMPLICATIONS

- On September 9, 2020, Government announced notional funding of up to $42.3 million to support the HaH initiative; however, based on further analysis, the Ministry allocated $1.699 million in 2020/21 to the 5 regional health authorities to support HaH planning activities and prototypes being initiated in the Northern Health Authority and Vancouver Island Health Authority.
- Budget 2021 provides an allocation of up to $900 million from the Pandemic and Recovery Contingencies for health-related needs. It can also be used to support a number of new health strategies such as the HaH initiative (page 8 and 9 of Budget 2021 – Budget and Fiscal Plan 2021/22 – 2023/24).

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[5] 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.

[6] 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 - FACT SHEET

**Approved:**
May 5, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 9, 2021 – Janice Butler obo Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Hospital Congestion

### TOPIC

Hospital congestion happens when hospitals consistently operate above their capacity, impacting patient flow, access to and timely delivery of services. Drivers of hospital congestion include demographic changes in the BC population, seasonal fluctuations, and more patients designated as needing Alternate Levels of Care (ALC) waiting for transition to more appropriate care setting.

### CURRENT SITUATION

In 2020/21, 5 out of 84 hospitals in BC had annual occupancy rates over 100%[1]. In response to the COVID-19 pandemic, several temporary strategies to decongest hospitals in preparation for an influx of infected individuals were put in place. The average hospital occupancy rate during the period April 1 – March 31, 2021 was reduced to 90% (see Table 1).

### KEY FACTS

- For fiscal years 2015-2019, the average BC hospital occupancy rate ranged from 101.7% (2019) to 103.5% (2016). In 2020/21, the occupancy rate was 90.1%[2]. This metric considers the number of inpatients and the number of acute care beds available, excluding surge beds.
- Temporary measures undertaken to decongest hospitals in response to anticipated increases in patient volume during the early stages of COVID-19 included: postponement of all non-urgent scheduled surgery (reintroduced in May 2020); amendments to long term care admissions processes; and decanting of hospital beds.

**Table 1**: Hospital Occupancy Rates Pre and During COVID-19 Pandemic[3]

| Health Authority | Pre-COVID-19 Hospital Occupancy Rate (Apr 1 2019 -Mar 31, 2020) | During COVID-19 Hospital Occupancy Rate (Apr 1 2020 – Mar 31, 2021) | Percentage Point Change |
|---|---|---|---|
| Interior Health Authority | 101.1% | 89.1% | -12 |
| Fraser Health Authority | 106.2% | 94.5% | -11 |
| Vancouver Coastal Health Authority | 98.4% | 89.6% | -9 |
| Island Health Authority | 103.4% | 90.0% | -13 |
| Northern Health Authority | 103.1% | 87.8% | -15 |
| Provincial Health Services Authority | 74.0% | 62.0% | -16 |
| BC Average | 101.7% | 90.1% | -11 |

- The Ministry of Health and health authorities continue to manage ongoing hospital occupancy in several ways by considering the input, through-put, and output of patients. A specific COVID-19 Surge Management Protocol was developed to help guide a consistent approach to surge planning across BC.
  - Activities that address patients arriving at hospitals (input) include:
    - All health authorities have surge plans to accommodate variation in arrivals
    - Added surge staffing to support anticipated growth
    - More surgeries are provided as day surgeries so patients can return home faster
    - When required, decanting to smaller community hospitals
    - Strengthening community and patient-centred care to support the quality and safety of care and reduce the need for patients to come to hospital
    - As part of comprehensive primary care services, there have been increases to the availability and accessibility of urgent care services, depending on community need, existing resources and infrastructure. (Refer to *Urgent Family Care Centres Fact Sheet*)
    - The "Assess, See, Treat, and Refer" initiative permits paramedics to provide treatment on scene and make a referral to a more appropriate service when a hospital visit is not needed. (Refer to *Secondary Triage Fact Sheet*)

[1] Source: HAMIS/OASIS, HSIAR (for 2020/2021) https://hlth.sp.gov.bc.ca/sites/HLTHSP/PI/HIP/measurement/Report/Forms/AllReports.aspx
[2] Source: HAMIS/OASIS, HSIAR (for 2020/2021) https://hlth.sp.gov.bc.ca/sites/HLTHSP/PI/HIP/AP/Analytics%20Product%20Library/Forms/Alphabetical.aspx
[3] Source: HSIAR SharePoint/Occupancy Rate Reports 20_21 Q4, dated April 26, 2021

- Activities that address more efficient patient movement (through-put) include:
  - Improving the coordination and access of acute care resources and higher-level care within the province, with improved facilitation and coordination of inter-facility transfers and timely return of inpatients to their home health authorities
  - Increasing bed capacity through hospital renovations and new construction.
- Activities that support patients who no longer need hospital care (output), include:
  - Designating teams to plan discharges and facilitate transitions from hospitals
  - Work to transition patients designated as ALC into more appropriate care settings. (Refer to *Alternate Level of Care Fact Sheet*)
  - Providing more supports in patients' homes. (Refer to *Hospital at Home Fact Sheet*)
  - Creating more assisted living and residential beds so that patients can be moved from hospital into suitable accommodation as soon as possible; and,
  - Implementing policy requiring assessments for residential care be completed in the community rather than in a hospital setting to reduce ALC rates.

**Table 2:** Provincial Hospital Decongestion Performance Indicators

| Performance Indicator | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 YTD |
|---|---|---|---|---|---|---|---|
| % of medical cases with lengths of stay lower than or equal to the expected lengths of stay[4] | 65% | 64% | 63% | 63% | 63% | 63% | 65% |
| % of surgical cases with lengths of stay lower than or equal to the expected lengths of stay[5] | 70% | 68% | 69% | 69% | 66% | 67% | 68% |
| ALC days as a percentage of total days[6] | 13% | 13% | 14% | 13% | 14% | 15% | 13% |
| Hospital occupancy (including ALC)[7] | 103% | 103% | 103% | 103% | 103% | 102% | 90% |
| % of ED patients admitted to an inpatient bed within 10 hours of triage[8] | 49% | 47% | 44% | 46% | 43% | 41% | 57% |
| Unplanned Readmission Rates to Hospitals within 30 days[9] | 10.1% | 10.2% | 10.2% | 10.3% | 10.1% | 10.2% | 10.5% |

**Table 3:** Comparing BC with 2019/20 National Indicators[10]

| Performance Indicator | BC | Canada |
|---|---|---|
| 90th percentile emergency department wait time for physician initial assessment (90% of patients wait less than this time) | 3.1 hours | 4.1 hours |
| Unplanned Readmission Rates to Hospitals within 30 days | 10.0% | 9.5% |
| Median days hospital stay extended until home care services ready | 7 days | 8 days |

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

May 21, 2021 – Janice Butler obo Teri Collins, ADM, Health Services Division

June 1, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

[4] Source: DAD, HSIAR, Ministry of Health (2020). Health Information Portal: Policy, Analytics & Monitoring. *LOS versus ELOS Medical*. (Data as of December 15, 2020.)

[5] Source: DAD, HSIAR, Ministry of Health (2021). Health Information Portal: Policy, Analytics & Monitoring. *LOS versus ELOS Surgical*. (Data as of January 6, 2021.)

[6] Source: DAD, HSIAR, Ministry of Health (2020). Health Information Portal: Policy, Analytics & Monitoring. *Alternate Level of Care Days*. (Data as of December 15, 2020)

[7] Source: HAMIS/OASIS, HSIAR, Ministry of Health (2021). Health Information Portal: Policy, Analytics & Monitoring. *Hospital Occupancy Rate.* (Data as of April 26, 2021)

[8] Source: NACRS, HSIAR (NACRS hospitals in BC), Ministry of Health. (2020). Health Information Portal: Policy, Analytics & Monitoring. *Emergency Department Admissions With a Length of Stay pf 10 Hours or Less from Triage* (Data as of December 15, 2020)

[9] Source: DAD, HSIAR, Ministry of Health (2020). Health Information Portal: Policy, Analytics & Monitoring. *Readmissions*. (Data as of August 19, 2020.)

[10] Source: CIHI, Your Health System – British Columbia. *Emergency Department Wait Time for Physician Initial Assessment (90% Spent Less, in Hours) details for British Columbia*. Accessed February 23, 2021. https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/034/2/C9001/

# LEGISLATIVE SESSION - FACT SHEET

# Hospitals and COVID-19 (Capacity)

## TOPIC

In response to the COVID-19 health crisis, hospital strategies have been developed to manage normal routine demand for health care services and the added pressures of the COVID-19 pandemic.

## CURRENT SITUATION

- As we have seen in other parts of the world, COVID-19 has the potential to overwhelm hospital systems putting both COVID-19 and non-COVID-19 patients at risk as well as placing a tremendous burden on front line staff.
- The Ministry of Health and health authorities have been actively planning and managing to create acute care system capacity to manage surge challenges related to COVID-19.

## KEY FACTS

WAVE 1

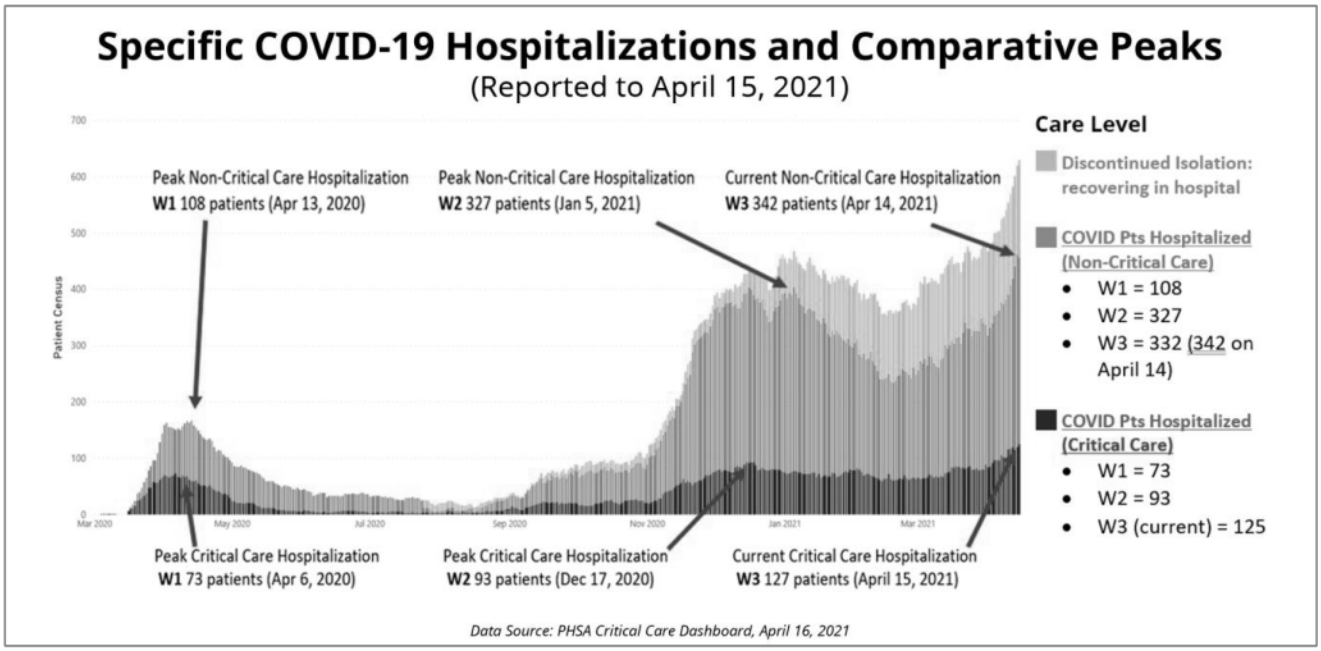
As part of the early response to the COVID-19 health crisis, and in anticipation of an influx of infected patients, several temporary strategies were put in place to create immediate capacity in acute care facilities (including reducing surgical services and decanting hospitals).

WAVE 2

- Following the first COVID-19 wave and the resumption of surgical services, expanded strategies were put in place in the fall/winter 2020/21 including:
  - Enhanced surge capacity planning for acute care hospitals based on various COVID-19 modelling scenarios.
  - Maintaining Essential Visitor Policies (see *COVID-19 Essential Visitor Policy fact sheet*)
  - Emergency departments employed COVID-19 (respiratory) and routine (non-respiratory) pathways; COVID-19 "cohorted" wards were utilized.
  - A strategy for monitoring ventilator usage across all sites was activated along with a process to access provincial pandemic supplies.
  - Active monitoring of critical care capacity across the province.
  - Strengthening patient transport and access to care in rural and remote areas through the implementation of the Rural, Remote and Indigenous Community Framework.
  - Implementation of "hospital at home" model to provide added acute care capacity (see *Hospital at Home Fact Sheet*).
- All acute care facilities continue to actively manage bed capacity (see *Hospital Congestion Fact Sheet*).
- The Ministry of Health and health authorities collaboratively developed a COVID-19 surge management framework which provides strategic direction through agreed upon assumptions, principles, lessons learned and modelling.
- All of BC's 5 regional health authorities and the Provincial Health Services Authority have completed regional surge plans in line with the Surge Management Protocol in preparation for future waves of COVID-19.
- The Ministry also created an Acute Care Surge Management Protocol to capture best practices and provide an outline for active management of pandemic surge, as well as system-level monitoring and oversight led by the Ministry in partnership with health authorities.
- At the facility level, all of BC's primary COVID-19 hospitals have undertaken surge planning with consideration for active management of pre-surge capacity, reference points or escalation triggers, incident management structures, health human resources, emergency department triage and diversion, and, if required, deferral of services.
- A Provincial Capacity Management Strategy is in place to guide decision-making for "load-levelling" of patients and movement across health authorities if required.

WAVE 3:

- Wave 3 is currently placing unprecedented pressures on critical care capacity, particularly in the Lower Mainland.




- Strategies are in place to increase critical care resource capacity through directed, short term reductions in surgical activities in specific hospitals in the lower mainland to address staffing demands.
- To bridge the period prior to realizing the full benefit of surgical reductions, an additional temporary strategy to reduce critical care transfers into the lower mainland was also enacted.
- This strategy was approved by the Ministry of Health and senior health authority executive with advice and support from the Critical Care Services Executive Committee and the Provincial Patient Transport Services Strategic Operations Committee with the following considerations:
    - Patients requiring quaternary or specialized services continue to be transferred to the appropriate lower mainland facility as per usual process.
    - Where clinically appropriate, critical care patients outside the lower mainland area who would typically be transferred into the lower mainland via established referral pathways were considered for alternative referral to the less impacted areas of Vancouver Island Health Authority and Interior Health Authority.
    - The process was coordinated by BC Patient Transfer Network.
    - The Critical Care Services Executive Committee, along with Trauma Services BC provided high level criteria to the BC Patient Transfer Network.
    - A provincial Critical Care Dashboard is in place, providing daily monitoring of all critical care capacity across the province including regularly staffed beds and “surge” capacity.
    - The dashboard also monitors ventilator distribution and use (see *Pandemic Mechanical and Fleet Ventilators Fact Sheet*).
    - An allocation framework is in place for distribution of ventilators across acute care sites in the province.

## FINANCIAL IMPLICATIONS

Not known at this time.

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**Approved:**
April 26, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## 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.

### CURRENT SITUATION

- Health authorities provide monthly data to the Ministry on the number of facilities under each service type, described in the Act and its Regulations.
- Licensed community care facilities include both publicly subsidized and private pay models.

### KEY FACTS

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.

Advice/Recommentations

### FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 15, 2021 – Teri Collins, ADM, Health Services Division

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[1] Data current to February 3, 2021 Licensed Facilities by Service Type Spring 2021/ Source: Emails from HA Community Care Licensing Programs.

[2] 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.

[3] The increase in overall numbers of child day care is likely related to re-opening after a temporary closure due to COVID-19.

# LEGISLATIVE SESSION - FACT SHEET

## Licensed Community Care Facilities

### TOPIC

Community care facilities are regulated under the *Community Care and Assisted Living Act* (CCALA) and are licensed through the regional health authorities.

### CURRENT SITUATION

- Health authorities provide monthly data to the Community Care Facility Licensing branch of the Ministry of 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.

### KEY FACTS

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 health authority[1].

Advice/Recommentations

### FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 22, 2021 - Teri Collins, ADM, Health Services Division

April 20, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

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[1] Data current to February 2, 2021 Licensed Facilities by Service Type Spring 2021/ Source: Emails from HA Community Care Licensing Programs.

[2] Fraser Health reports each service type separately, therefore the number of 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.

[4] Long-term care includes CCALA and *Hospital Act* facilities. Data source: Home and Community Care Beds Inventory, HSIAR.

[5] The BC total does not equal the sum of HA facilities because some facilities are contracted by more than one health authority.

# LEGISLATIVE SESSION - FACT SHEET

# Long-Term Care – COVID-19 Impact Response

## TOPIC

- Since the beginning of the COVID-19 pandemic the Ministry, in consultation with BC's Provincial Health Officer (PHO), mobilized to rapidly respond to the risk of COVID-19 transmission in congregate care settings.
- Several enhanced protective measures have been put in place to minimize the risk for introduction and transmission of COVID-19 in long-term care (LTC) homes and seniors' assisted living (AL) residences and protect those most vulnerable to serious illness from COVID-19.
- As the province continues to respond to and manage the COVID-19 pandemic in BC, response measures taken have been reviewed and amended based on transmission trends in the province as well as the system, resident, and family impacts.

## CURRENT SITUATION

- As of June 1, 2021, there have been 249 COVID-19 outbreaks in LTC (202 outbreaks), AL (27 outbreaks) and Independent Living (IL) (20 outbreaks) in BC.
- As of June 1, 2021, the outbreaks in LTC, AL and IL have included:
  - 4,276 cases in LTC (2,588 residents and 1,688 staff)
  - 202 cases in AL (143 residents and 59 staff)
  - 223 cases in IL (174 residents and 49 staff)
  - 779 deaths in LTC (all residents), 18 deaths in AL (all residents) and 11 deaths in IL (all residents)
- The Ministry's *Management of COVID-19: Health Sector Plan for Fall/Winter 2020/21* identified four transmission scenarios for planning purposes leading into the fall/winter season. Based on this, risk-based policies for admissions and transfers were developed to support a planned, consistent, and measured response while maintaining a person-centred approach and allowing for flexibility in response to address regional needs.
- The Ministry's *Outbreak Management and Response Protocol (Fall, 2020),* developed after feedback from the sector, continues to guide a systematic and fulsome approach to supporting the management of outbreaks, including assessment of baseline staffing levels, audit of infection, prevention and control (IPC) measures, screening of staff/residents/visitors, assessment of outbreak management plans, deployment of Rapid Response Teams, and enhanced staffing in facilities. As of April 1, 2021, visitor restrictions in LTC and AL were eased to allow for more social visitors, ensuring all residents are supported to have regular, frequent social visitation.
- In late December 2020, BC began administering COVID-19 vaccinations in LTC and seniors' AL settings as part of Phase 1 of BC's Immunization Plan which focuses on high-risk populations. Significant progress has been made to-date (June 1, 2021):[1]

**Long-Term Care: COVID-19 Vaccinations**

| Region | Residents | | Staff | |
|---|---|---|---|---|
| | Dose 1 | Dose 2 | Dose 1 | Dose 2 |
| Fraser | 9,942 | 8,614 | 12,253 | 7,869 |
| Interior | 6,293 | 5,222 | 8,181 | 5,421 |
| Northern | 1,145 | 951 | 1,214 | 646 |
| Vancouver Coastal | 8,196 | 7,083 | 10,253 | 7,003 |
| Vancouver Island | 7,153 | 6,101 | 9,456 | 6,665 |
| BC | 32,729 | 27,971 | 41,357 | 27,604 |

[1] Provincial Immunization Registry (PIR), last accessed by HSIAR May 16, 2021

**Assisted Living: COVID-19 Vaccinations**

| Region | Residents | | Staff | |
|---|---|---|---|---|
| | Dose 1 | Dose 2 | Dose 1 | Dose 2 |
| Fraser | 4,826 | 3,807 | 2,714 | 1,473 |
| Interior | 2,451 | 1,660 | 1,182 | 470 |
| Northern | 321 | 236 | 194 | 108 |
| Vancouver Coastal | 1,608 | 1,047 | 1,066 | 588 |
| Vancouver Island | 1,818 | 1,351 | 1,388 | 697 |
| BC | 11,024 | 8,101 | 6,544 | 3,336 |

- It should be noted that comparing this data to other data sets (i.e., Ministry LTC and AL facility and bed data) will not align for the following reasons:
  - Facility data is a point in time, current to March 31, 2021 and new LTC beds/AL units may have been added since this date
  - Resident and staff turnover – as new residents are admitted and new staff come on board they are being vaccinated
  - Vaccination data may, in some areas, include short stay beds where clients have been vaccinated or Independent Living units that are co-located with AL
  - Occupancy in AL where units may be occupied by more than one client (e.g., spouses)
- The Ministry is currently reviewing the impact of vaccination on COVID-19 response measures that have been implemented in LTC and seniors' AL settings. The Ministry will revise these measures as appropriate.

## KEY FACTS

**Infection Prevention and Control**

- On March 13, 2020 (updated May 19th, June 30th and May 5th 2021), the Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors' Assisted Living (IPC Requirements for COVID-19)[2] was released to support IPC practices and clinical decision-making in key areas, including:
  - Screening protocols for residents, staff, and visitors;
  - Allocation and use of personal protective equipment;
  - Enhanced cleaning practices;
  - Management of care for residents with COVID-19; and
  - Outbreak protocols, such as notification/reporting requirements, and enhanced testing.
- BC made Fluzone High-Dose available to all LTC/AL residents – Fluzone HD is a higher dose vaccine designed specifically to protect people over 65 from influenza.

**Personal Protective Equipment**

- Managing the supply and usage of scarce personal protective equipment (PPE) supplies early on in the pandemic required a collaborative approach and in response, to facilitate equal access to PPE, the Ministry provided access to the provincial supply chain for all LTC and AL operators.
- The Ministry has established a robust system, for facilities to access supply, which is still available to all operators.
- Between March 2020 – February 2021:
  - Vancouver Coastal Health Authority (VCHA) provided $5.4M[3] of PPE to LTC sites within their region, and
  - Fraser Health Authority (FHA) provided $13.8M[4] of PPE and critical supplies to LTC/AL sites within their region.

[2] Initial title of this document was *Infection Prevention and Control (IPC) for Novel Coronavirus (COVID-19): Interim Guidance for Long-Term Care and Seniors Assisted Living;* title update included in June 30, 2020 version.
[3] HA email from Carolyn Bell, Feb 4, 2021
[4] HA email from Carolyn Bell, Feb 4, 2021

**Visitor Restrictions**

- On March 17, 2020, the PHO advised LTC homes and AL residences to restrict visitors to essential visits only to minimize the risk of introduction of COVID-19 and allow staff to focus on caring for residents, rather than monitoring and screening visitors.
- On June 30, 2020, the Ministry updated the IPC Requirements for COVID-19 to include practice requirements for operators to allow for social visits in LTC and AL.
- On January 7, 2021, the Ministry released an *Overview of Visitors in Long-Term Care and Seniors' Assisted Living,* a guidance document, intended to support a consistent approach to visits in LTC and AL that enables person-centred care. On February 5, 2021, the visitor restrictions became legally grounded in the PHO *Visitation and Visitor Appeal and Review Order.* On February 25, 2021, the Ministry released an update to the January 7th guidance in response to issues raised by the Ombudsperson related to the visitor appeals process (i.e., timeframe for responses, written reasons for decision).
- On March 25, 2021, the PHO advised easing of (social) visitor restrictions for LTC homes and seniors' AL residences. The following changes came into effect April 1, 2021:
    - All residents are entitled to regular, frequent, and routine opportunities for social visitation. Any limitations on frequency and duration of visits are only by exception, specifically to ensure WorkSafe BC and facility site safety plans are adhered to.
    - Visits must allow for a minimum of 60 minutes, if desired by the resident/family.
    - Requirement for a 'single designated social visitor' has been removed to allow additional family and friends to visit.
    - Number of visitors allowed per visit has been increased (up to two visitors, plus a child). Outdoor visits may include more visitors and must occur in alignment with current PHO guidelines and follow IPC measures.
    - Location for visits has been revised to enable visits in resident rooms without staff monitoring.
    - Physical touch is now allowed to occur between a visitor and resident with appropriate IPC measures in place (e.g., hand hygiene, masks); and
    - Residents are now supported to go on appropriate (i.e., in accordance with public health guidance) outings, with no requirements for isolation upon return.
- On March 25, 2021, the PHO also announced changes (effective April 1, 2021) to support quality of life through additional opportunities for social and emotional connection for residents in LTC and seniors' AL, including:
    - Removing physical distancing requirements between residents; and
    - Resuming communal dining and small group social or recreational activities for residents, within a facility unit or floor.

**Admissions and Transfers and In Facility Respite**

- On March 18, 2020, the Ministry advised health authorities (HAs) to limit movement within and across facilities and temporarily suspend specific programs to limit potential exposure from community by temporarily suspending interfacility transfers (i.e., LTC to LTC, AL to AL), except in circumstances of intolerable risk; prioritize admissions to LTC from acute care over those from community and AL; and temporarily suspend the provision of in-facility adult day programs, and in-facility respite, except in circumstances of intolerable risk.
- On April 27, 2020, the Ministry advised HAs and operators to resume admissions from community as per their previous waitlist and that all admissions from community must be put under isolation with standard precautions (i.e., mask, gloves, eye protection) for 14 days.
- On July 15, 2020, the Ministry advised HAs and operators that the provision of in-facility respite and inter-facility transfers should resume with certain limitations.
- On November 27, 2020, in recognition of significant increase in transmission of COVID-19 in both Fraser Health Authority (FHA) and Vancouver Coastal Health Authority (VCHA), the Ministry advised FHA and VCHA to re-impose the limitations on admissions, transfers, in-facility ADP and in-facility respite.
- On February 23, 2021, with the significant decrease in LTC outbreaks and the progress of Phase 1 of the provincial Immunization Plan, the Ministry advised FHA and VCHA to resume admissions and transfers under the guidance of their Medical Health Officers (MHO), while still maintaining priority admissions from acute care, and 14-day isolation requirements.

- On April 1, 2021, the requirement for 14-day isolation was removed for admissions into LTC or AL, with COVID-19 immunization being offered at the earliest opportunity.

**Temporary Absences**

- On March 31, 2020, the Ministry modified policy direction regarding temporary absences from LTC homes to support families wanting to care for loved ones at home, and to address anticipated pressures on the acute care system, by extending the time that a resident can be temporarily absent for personal reasons, from 30 days to 90 days. To allow for temporarily vacant beds to be utilized in support of surge capacity, fees were waived for absent residents, if return was not imminent.
- On May 5, 2020, based on feedback from the Office of the Seniors Advocate (OSA) and a decreased need to support surge capacity, revisions to policy regarding temporary absences from LTC were made. The allowance for the time a resident can be temporarily absent for personal reasons remains extended from 30 days to 90 days. During this time, residents continue paying their assessed client rates and LTC homes maintain clients' beds in their absence.

**Single Site Initiative**

- Beginning March 26, 2020, a series of orders were made by the PHO to plan for the implementation of single site work locations to minimize the movement of staff between facilities (See Single Site FS).
- On June 18, 2020 it was announced that staff assignment directives have been issued and single site staffing has been implemented at 100% of the 501 sites in-scope of the PHO/EPA Orders. (As of February 3, 2021, 2 more sites were added to the Single Site Initiative tracking, bringing the total to 503.)
    - 100% of the 8,878 employees previously working at multiple impacted sites, have been assigned to work at a single site.[1]
    - Employee preference was considered where possible in staffing assignment.

**Outbreak Management and Response**

- Beginning with the first outbreaks in VCHA, HAs have provided rapid response to support facilities experiencing an outbreak. Support included IPC guidance, PPE support, clinical leadership, and public health guidance.
- During the late summer/fall based on feedback from operators, the Ministry further strengthened the support for the LTC sector and response to outbreaks including:
    - Enhanced coordination and communication between the Ministry/HAs, and LTC/AL providers
    - Strengthened data collection processes to better understand the human and financial impacts within LTC/AL
    - Revised policies to meet the changing impacts of COVID-19 and needs of clients/operators
    - Outbreak management protocols were shared across all HAs, and embedded in the *COVID-19: Lower Mainland Operational Management Response* (initiated in November, finalized December 14, 2020)
    - Strengthened mental health supports for staff

**Long Term Care Staffing**

- On September 9, 2020, Government announced initiative to incrementally hire over 7,000 individuals into the health sector over three initiatives as part of the Health Recruitment Initiative (HRI):
    - 2,000 net new FTEs to support visitation in LTC and AL, including scheduling family visits, assisting with IPC practices for visiting, and providing information on necessary steps and processes for visiting.
    - 3,000 net new Health Care Support Worker (HCSW) FTEs through the Health Careers Access Program (HCAP), an innovative strategy to integrate staff without prior healthcare education into the workplace while providing funding and support to complete the Health Care Assistant (HCA) education and training program.
    - Approximately 2,000 existing vacancies will benefit from a focused provincial recruitment campaign highlighting the opportunities available in BC for a variety of roles in LTC and AL.
- As of June 2, 2021, nearly 5,000 positions have been filled and hiring continues.
    - 1,521 FTEs have been hired to support safe visitation
    - 1,864 participants have been hired into Health Care Support Worker positions under HCAP
    - 1,945 baseline vacancies have been filled

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

- For 2019/20 HAs reported spending approximately $2.223 billion related to the entire LTC sector and $92.9 million related to AL services.
- The Ministry has provided the following additional funding to support the LTC sector:
  - In 2019/20, Government Financial Information United Way of the Lower Mainland ($50 million announced, Government Financial Information Government Financial Information

    Government Financial Information and,
  - 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 to be used 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.
- As part of the Ministry's access to $1.616 billion from the Contingencies (All Ministries) Pandemic Response and Economic Recovery Vote 52, nearly $322M is being used to support the LTC sector:
- As of March 31, 2021, $26.4 million provided through the regional HAs on a one-time basis to LTC and AL operators to address costs incurred between March 1, 2020 and June 30, 2020, including additional screening, sick time/self isolation, changes to services (i.e., meal delivery), enhanced cleaning and other IPC measures.
- As of March 31, 2021, $116.4 million for LTC and AL facilities (including HA owned/operated sites) to hire up to four additional FTEs dedicated to supporting safe visitation, including administration, and scheduling visits, and ensuring IPC measures for COVID-19 are followed.
- $141.5 million was provided in 2020/21 to support wage-levelling costs related to implementing the PHO's single-site orders.
- As of March 31, 2021, $34.6 million to provide wage and benefits supports while individuals train as HCAs (HCAP).
- As of March 31, 2021, $3.0 million to provide education for 3,000 new HCAs, through the HCAP.
  In addition, 2020/21, through the Ministry of Finance (MoF):
- In partnership with the federal government, the province provided temporary pandemic pay (TPP) for more than 250,000 front-line health care and social sector workers. Eligible front-line workers received a lump-sum payment equivalent to $4 per hour for a 16-week period, starting March 15, 2020; and,
- As reported, up to April 19, 2021, MoF has paid out approximately $133.06 million of TPP to HAs and their contracted service providers which include LTC and AL operators. (NOTE: TPP questions to be referred to Minister of Finance).
- Budget 2021 provides $585 million over three years to continue support for the HCAP program to train, recruit and employ up to 3,000 health care workers; $67.5 million over three years to support expansion of home support services which includes helping seniors with daily living; and, up to $900 million from the Pandemic and Recovery Contingencies for health related needs including support for screening and single site orders.

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**Approved:**
May 17, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
May 26, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 3, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Appendix A – Chronological Order of Actions Taken

- **March 13, 2020** - (updated May 19th and June 30th), the Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors Assisted Living (IPC Requirements for COVID-19)
- **March 17, 2020** - BC's Provincial Health Officer (PHO) declared a public health emergency due to COVID-19
- **March 17, 2020 -** PHO advised LTC homes and AL residences to restrict visitors to essential visits only
- **March 18, 2020 -** a provincial state of emergency was declared under the Emergency Program Act, to support the coordinated response to COVID-19 across all levels of government
- **March 18, 2020** - the Ministry advised health authorities (HAs) to limit movement within and across facilities and temporarily suspend specific programs except in circumstances of intolerable risk; prioritize admissions to Long Term Care from acute care; and temporarily suspend the provision of in-facility adult day programs, and in-facility respite, except in circumstances of intolerable risk
- **March 26, 2020** - Ministry provided access to the provincial supply chain for all LTC and AL operators to facilitate equal access to Personal Protective Equipment
- **March 26, 2020 -** a series of orders were made by the PHO to plan for the implementation of single site work locations to minimize the movement of staff between facilities (See Single Site FS)
- **March 31, 2020** - (updated May 5th) the Ministry modified policy direction regarding temporary absences from LTC homes to support families wanting to care for loved ones at home by extending the time that a resident can be temporarily absent from 30 days to 90 days while maintaining their bed and maintain their waitlist position for a preferred care home
- **April 3, 2020 -** $10 million was provided to the BC Care Providers Association to facilitate the EquipCare program to support LTC and AL operators, publicly funded and private, with IPC and infrastructure enhancements
- **April 27, 2020** - the Ministry advised HAs and operators to resume admissions from community as per their previous waitlist and that all admissions from community must be put under isolation with standard precautions (mask, gloves, eye protection) for 14 days
- **May 5, 2020** – Revisions to policy direction regarding temporary absences from LTC homes to support families wanting to care for loved ones at home by extending the time that a resident can be temporarily absent from 30 days to 90 days while maintaining their bed and maintain their waitlist position for a preferred care home
- **May 19, 2020** - the Ministry, in partnership with the federal government, announced Temporary Pandemic Pay for more than 250,000 front-line health and social workers
- **May 19, 2020 -** updated Infection Prevention and Control Requirements for COVID-19 in Long-Term Care and Seniors Assisted Living
- **June 18, 2020 -** staff assignment directives have been issued and single site staffing has been implemented
- **June 30, 2020 -** the Ministry updated the IPC Requirements for COVID-19 to include practice requirements for operators to allow for family/social visits in LTC and AL
- **June 30, 2020 -** $26.56 million was announced to flow through the regional HAs on a one-time basis to LTC and AL operators to address costs incurred between March 1 and June 30, 2020
- **June 30, 2020:** $122.4 million was announced for LTC and AL facilities (including HA owned/operated sites) to hire up to four additional FTEs dedicated to supporting safe visitation, including administration, and scheduling visits and ensuring IPC measures for COVID-19 are followed
- **July 15, 2020** - the Ministry advised HAs and operators that the provision of in-facility respite and inter-facility transfers should resume with certain limitations
- **August 2020 –** implementation of the LTC monitoring tool to collect staffing and expenditure data from LTC providers
- **August 26, 2020 -** the Ministry approved a selective re-opening of ADP sites that operate in a standalone facility or are co-located within a long-term care home but do not share space/staff/equipment
- **September 2020 -** the Ministry released Management of COVID-19: Health Sector Plan for Fall/Winter 2020/21 which proposed actions to restart many health services and manage ongoing operations over the coming based on possible transmission scenarios
- **September 9, 2020 -** Government announced the hiring of 7,000 individuals into the health sector over three initiatives as part of the Health Recruitment Initiative

# LEGISLATIVE SESSION - FACT SHEET

- **October 2020 -** BC made available Fluzone-High Dose to all LTC/AL residents
- **November 27, 2020 -** the Ministry advised FHA and VCHA to re-impose the limitations on admissions, transfers, in-facility ADP and in-facility respite
- **November-December 2020 -** Proactive Risk Assessments: non-outbreak sites are assessed through on-site audits that evaluate:
- Facility IPC practices
- Staff and resident screening processes
- Outbreak prevention and management planning
- Baseline staffing levels
- **November-December 2020** – Ministry worked with HAs to identify additional preventative and outbreak management measures, including on-site audits that evaluate:
- Facility IPC practices
- Staff and resident screening processes
- Outbreak prevention and management planning
- Baseline staffing levels
- Additional clinical and administrative Leadership presence
- Appropriate Staffing Levels
- Active screening of Staff Before Every Shift
- Active Surveillance of Residents
- Appropriate Use of PPE
- **October 2020-onwards:** Health Authorities now deploy outbreak management teams to all sites on outbreak status (this team includes the Medical Health Officer, public health nursing, infection prevention control, operations lead). **As of mid-January 2021**:
    - VCH has deployed 30 response teams to support facilities in outbreak and each outbreak site has an operations lead assigned to monitor and support the site.
    - FHA has deployed 87 response teams to support facilities in outbreak and each outbreak site has an operations lead assigned to monitor and support the site.
    - Sites with significant outbreaks and/or significant issues are also provided additional on-site leadership support to ensure effective management of outbreaks.
- **December 14, 2020 –** Ministry finalized the *COVID-19: Lower Mainland Operational Management Response (subsequently applied across all HAs)*
- **December 2020** – Vaccination roll out in LTC/AL began
- **January 7, 2021** - the Ministry released an *Overview of Visitors in Long-Term Care and Seniors' Assisted Living,* guidance document
- **February 5, 2021** - visitor restrictions became legally grounded in the PHO *Visitation and Visitor Appeal and Review Order*
- **February 23, 2021** - Ministry advised FHA/VCH to resume admissions and transfers under the guidance of their MHO, while still maintaining priority for admissions from acute care, and 14 day isolation
- **February 25, 2021** – Ministry updated the January 7 Visitor guidance to address issues highlighted by Ombudsperson
- **March 4, 2021**- Outbreak management Protocol for Acute Care, LTC and Seniors AL settings released
- **March 25, 2021** –. the PHO advised easing of (social) visitor restrictions for LTC homes and seniors' AL residences. The following changes **came into effect April 1, 2021**:
    - All residents are entitled to **regular, frequent, and routine** opportunities for social visitation. Any limitations on frequency and duration of visits are only by exception, specifically to ensure WorkSafe BC and facility site safety plans are adhered to.
    - Visits must allow for a minimum of 60 minutes, if desired by the resident/family.
    - Requirement for a **'single designated social visitor' has been removed** to allow additional family and friends to visit.

  - **Number of visitors** allowed per visit has been increased (up to two visitors, plus a child). Outdoor visits may include more visitors and must occur in alignment with current PHO guidelines and follow IPC measures.
  - Location for visits has been revised to enable **visits in resident rooms** without staff monitoring.
  - **Physical touch** is now allowed to occur between a visitor and resident with appropriate IPC measures in place (e.g., hand hygiene, masks); and
  - **Residents are now supported to go on appropriate (i.e., in accordance with public health guidance) outings,** with no requirements for isolation upon return.
- **March 25, 2021** – PHO also announced changes (**effective April 1, 2021**) to support quality of life through additional opportunities for social and emotional connection for residents in LTC and seniors' AL, including:
  - **Removing physical distancing** requirements between residents; and
  - **Resuming communal dining and small group social or recreational activities** for residents, within a facility unit or floor.
- **As of March 31, 2021 (funding announced in March 2020), $26.4 million** provided through the regional HAs on a one-time basis to LTC and AL operators to address **costs incurred between March 1, 2020 and June30, 2020,** including additional screening, sick time/self isolation, changes to services (i.e., meal delivery), enhanced cleaning and other IPC measures.
- **As of March 31, 2021 (funding announced in March 2020), $116.4 million for LTC and AL facilities** (including HA owned/operated sites) **to hire up to four additional FTEs dedicated to supporting safe visitation**, including administration, and scheduling visits, and ensuring IPC measures for COVID-19 are followed. **$141.5 million was provided in 2020/21 to support wage-levelling costs related to implementing the PHO's single-site orders**.
- **March 31, 2021 (funding announced in September 2020), $34.6 million to provide wage and benefits supports while individuals train as HCAs** (HCAP).
- **March 31, 2021 (funding announced in September 2020), $3.0 million to provide education for 3,000 new HCAs**, through the HCAP.
- **April 1, 2021, the requirement for 14-day isolation was removed** for admissions into LTC or AL, with COVID-19 immunization being offered at the earliest opportunity.
- **April 1, 2021 – Physical distancing requirements for LTC and AL residents removed**
- **April 1, 2021 – Social visitor restrictions in LTC and AL eased**
- **May 5, 2021 – IPC: Guidance for LTC and Seniors AL Setting released**

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Withheld pursuant to/removed as

Advice/Recommentations ; Government Financial Information

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Withheld pursuant to/removed as

Advice/Recommentations ; Government Financial Information

# LEGISLATIVE SESSION FACT SHEET

## Long-Term Care Funding Model Work

### TOPIC

The Ministry of Health has committed to developing a standardized province-wide funding model for long-term care (LTC) that will provide greater transparency, equity, consistency, and sustainability with respect to funding. In addition, the funding model will align funding with a provincial quality framework to support the delivery of quality care.

### CURRENT SITUATION

- The work on the LTC Funding Model is being co-led by Finance and Seniors Branches in the Ministry.
- The work is complex and is based on a "ground up" model development that touches on other key initiatives to improve LTC:
    - Increasing direct care hours to 3.36 Hours Per Resident Day on average;
    - Staffing Model Framework;
    - Development of a Provincial Quality Framework;
    - Implementation of the LTC Monitoring Tool- standardized data collection; and
    - Minister's mandate commitments (e.g., permanency of single site wage leveling).
- Planning and response for ongoing implications/impacts of COVID-19 work to date includes:

Advice/Recommentations

### KEY FACTS

- Work on the LTC Funding Model began prior to the COVID-19 pandemic but slowed over the past year while Ministry and health authority staff focussed on the pandemic response.
- While much progress has been made, further work is required:

Advice/Recommentations

# LEGISLATIVE SESSION FACT SHEET

Advice/Recommentations

## FINANCIAL IMPLICATIONS

In Key Facts above.

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**Approved:**

June 7, 2021 – Teri Collins, ADM, Health Services Division

June 7, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Long-Term Care Staffing (3.36 HPRD)

## TOPIC

To provide a summary of the impact of *Budget 2018* allocation of $240M over 3 years to increase direct care hours in long-term care (LTC) facilities as part of the 3.36 hours per resident day (HPRD) initiative.

## CURRENT SITUATION

- In 2020/21 (year 3 of the 3.36 HPRD initiative) the Ministry allocated $100M to increase direct care staffing in 243 facilities.
- As of April 1, 2020, all 5 health authorities were funded to meet or exceed the target of 3.36 HPRD, on average, across all facilities.
- As of 2020/21 Q4, all 5 health authorities are reporting achievement of the 3.36 HPRD target, on average, across all facilities.

Advice/Recommentations; Government Financial Information

## KEY FACTS

- 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 (HA) is required for safe quality of care. The target of 3.36 comprises 3.0 hours of direct nursing care and 0.36 hours of direct allied health care.
- *Budget 2018* allocated $240M over 3 years ($50M - 2018/19; $80M - 2019/20; $110M - 2020/21) to increase direct care hours in LTC facilities to ensure each HA will reach the target of 3.36 HPRD, on average, across all facilities by 2021. The year 3 investment of $110M continues as part of the Ministry's base budget.
- In 2020/21, $99.9M was allocated to the HAs and the following milestones were achieved as of April 1, 2020:
    - All 5 HAs funded to reach the target of 3.36 HPRD, on average, across all facilities.
    - All 108 HA -owned and operated facilities funded at a minimum of 3.36 HPRD.
    - No LTC facility funded below 3.00 HPRD (with the exception of 1 facility scheduled for closure in early fiscal 2021/22).
    - 246 of 299 (82%) facilities funded at 3.36 HPRD or higher (an increase of 202 facilities from 2016/17 baseline).
    - 243 of 299 (81%) facilities allocated incremental 3.36 HPRD investment funding.
- A summary of the 3.36 HPRD investment in 2020/21 is shown in Table 1 and 2

Table 1

| 3.36 HPRD Investment by HA | | | |
|---|---|---|---|
| HA | Hours | $ in M | # sites |
| FHA | 916,000 | $ 40.68 | 67 |
| VCHA | 667,000 | $ 31.08 | 45 |
| VIHA | 408,000 | $ 16.82 | 54 |
| IHA | 261,000 | $ 9.74 | 59 |
| NHA | 34,000 | $ 1.61 | 18 |
| Total | 2,286,001 | $ 99.94 | 243 |

Table 2

| 3.36 HPRD Investment by Ownership Type | | |
|---|---|---|
| Type | Hours | $ in M |
| O&O | 270,000 | $ 13.09 |
| PFP | 1,040,000 | $ 43.64 |
| PNP | 976,000 | $ 43.21 |
| | | |
| | | |
| Total | 2,286,000 | $ 99.94 |

- The HPRD impact as a result of this investment compared with the 2016/17 baseline, is shown in Table 3.

| Table 3 | | |
|---|---|---|
| HA | 2016/17 Baseline HPRD | 2020/21 Funded HPRD |
| FHA | 3.05 | 3.38 |
| VCHA | 3.03 | 3.37 |
| VIHA | 3.13 | 3.36 |
| IHA | 3.23 | 3.36 |
| NHA | 3.39 | 3.45 |
| Total | 3.11 | 3.37 |

## FINANCIAL IMPLICATIONS

- The number of facilities funded at 3.36 HPRD as a result of this investment compared with the 2016/17 baseline, is shown in Table 4 and 5.
  - All HA owned and operated facilities funded at a minimum of 3.36 HPRD.
  - 69 or 65% of private for profit (PFP) facilities funded at a minimum of 3.36 HPRD.
  - 69 or 81% of not-for-profit (PNP) facilities funded at a minimum of 3.36 HPRD.

Table 4

| HA | 2016/17 Baseline | | | 2020/21 Funded Budget | | |
|---|---|---|---|---|---|---|
| | < 3.36 | >=3.36 | Total | < 3.36 | >=3.36 | Total |
| FHA | 69 | 9 | 78 | 12 | 67 | 79 |
| VCHA | 47 | 9 | 56 | 14 | 44 | 58 |
| VIHA | 55 | 4 | 59 | 8 | 51 | 59 |
| IHA | 65 | 11 | 76 | 19 | 60 | 79 |
| NHA | 13 | 11 | 24 | 0 | 24 | 24 |
| Total | 249 | 44 | 293 | 53 | 246 | 299 |

Table 5

| Ownership Type | 2016/17 Baseline | | | 2020/21 Funded Budget | | |
|---|---|---|---|---|---|---|
| | < 3.36 | >=3.36 | Total | < 3.36 | >=3.36 | Total |
| O&O | 74 | 33 | 107 | 0 | 108 | 108 |
| PFP | 101 | 1 | 102 | 37 | 69 | 106 |
| PNP | 74 | 10 | 84 | 16 | 69 | 85 |
| Total | 249 | 44 | 293 | 53 | 246 | 299 |
| % to total | 85% | 15% | | 18% | 82% | |

- The number of facilities funded under 2.90 HPRD and 3.00 HPRD compared with the 2016/17 baseline, is shown in Table 6 and 7.
  - The number of facilities funded under 3.00 HPRD decreased from 88 of 293 (30%) at 2016/17 baseline to 1 of 299 (<1%) as of April 2020.
  - The number of facilities funded under 2.90 HPRD decreased from 75 of 293 (26%) at 2016/17 baseline to 1 of 299 (<1%) as of April 2020.
  - The one facility with funded HPRD less than 3.00 is West Vancouver Care Centre. As of May 2021, this site is in the process of closing and moving residents to the new Creekstone Care Centre.

| Table 6 | # of facilities | | | | # of facilities < 3.00 | | | | Change from 2016/17 Baseline | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HA | 2016/17 Baseline | 2018/19 Actual | 2019/20 Actual | 2020/21 Budget | 2016/17 Baseline | 2018/19 Actual | 2019/20 Actual | 2020/21 Budget | 2018/19 Actual | 2019/20 Actual | 2020/21 Budget |
| FHA | 78 | 78 | 79 | 79 | 46 | 18 | 12 | 0 | (28) | (34) | (46) |
| VCHA | 56 | 56 | 58 | 58 | 31 | 15 | 10 | 1 | (16) | (21) | (30) |
| VIHA | 59 | 59 | 59 | 59 | 8 | 6 | 4 | 0 | (2) | (4) | (8) |
| IHA | 76 | 77 | 79 | 79 | 0 | 1 | 0 | 0 | 1 | 0 | 0 |
| NHA | 24 | 24 | 24 | 24 | 3 | 1 | 0 | 0 | (2) | (3) | (3) |
| Total | 293 | 294 | 299 | 299 | 88 | 41 | 26 | 1 | (47) | (62) | (87) |

| Table 7 | # of facilities | | | | # of facilities < 2.90 | | | | Change from 2016/17 Baseline | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| HA | 2016/17 Baseline | 2018/19 Actual | 2019/20 Actual | 2020/21 Budget | 2016/17 Baseline | 2018/19 Actual | 2019/20 Actual | 2020/21 Budget | 2018/19 Actual | 2019/20 Actual | 2020/21 Budget |
| FHA | 78 | 78 | 79 | 79 | 44 | 1 | 1 | 0 | (43) | (43) | (44) |
| VCHA | 56 | 56 | 58 | 58 | 25 | 5 | 3 | 1 | (20) | (22) | (24) |
| VIHA | 59 | 59 | 59 | 59 | 3 | 2 | 1 | 0 | (1) | (2) | (3) |
| IHA | 76 | 77 | 79 | 79 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NHA | 24 | 24 | 24 | 24 | 3 | 0 | 0 | 0 | (3) | (3) | (3) |
| Total | 293 | 294 | 299 | 299 | 75 | 8 | 5 | 1 | (67) | (70) | (74) |

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

- $99.9M was allocated to the HAs in 2020/21.

Government Financial Information

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**Approved:**

June 4, 2021 – Kerri Harrison obo Philip Twyford ADM, Finance and Corporate Services Division

June 7, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

# MAiD – Temporary Process, Regulatory Practice Standard Changes and Drug Shortages during COVID-19

## TOPIC

Temporary changes to regulatory practice standards regarding the provision of Medical Assistance in Dying (MAiD) during COVID-19 public health emergency.

## CURRENT SITUATION

The College of Physicians and Surgeons of BC, the BC College of Nurses and Midwives and the College of Pharmacists of BC have all revised their respective practice standards or bylaws to provide temporary exceptions during the COVID-19 public health emergency. These changes support social distancing where possible and enable the return to inventory of any unused, sealed MAiD medications.

## KEY FACTS

- There are currently three processes in the requesting, assessment, and provision of MAiD in BC that require close contact between practitioners (physicians and nurse practitioners), patients, families, and the public, or that pose time constraints on practitioners. These include witnessing a patient's request, in-person assessments, and returning unused MAiD medications.
- A MAiD prescription includes two identical sealed kits of medications, one primary kit and one back-up kit. Practice standards do not permit community pharmacies to reuse sealed kits, and therefore unused medications are destroyed. Hospital pharmacies are permitted to reuse sealed kits as they are stored in a controlled environment.

<u>Witnesses for Patient Requests</u>

- Under federal law, a practitioner who provides MAiD must "(c) be satisfied that the request was signed and dated by the person — or by another person under subsection (4) — before two independent witnesses who then also signed and dated the request." Typically, patient requests are witnessed and signatures are provided in-person.
- Health Canada was consulted and advised that under this section of the legislation, witnesses must view the request being signed, but it does not have to be in-person; witnesses can either receive the request via email and countersign the request, or simultaneously sign their section over videoconference with the patient. Consultation with legal counsel indicated that only the videoconferencing option should be used.
- *Temporary change to MAiD process*: For the duration of the COVID-19 public health emergency, the requirement for the patient to sign and date the request before two independent witnesses may be satisfied by having the signing take place over video conference, with both patient and witnesses sending their respective pages of the form to the care coordinator.

<u>Telemedicine Assessments</u>

- Under the current provincial MAiD practice standards, "one of the practitioners, but not both, may provide their assessment by telemedicine provided that, during the telemedicine assessment, another regulated health professional is in physical attendance with the patient to act as a witness to the assessment".
- Practitioners expressed concerns that having to assess people in-person put them at additional risk of exposure to COVID-19, and visitor restrictions at many facilities limited access to patients.
- There is also no capacity to provide regulated health professionals as witnesses during the public health emergency. Practitioners requested the ability to temporarily conduct these assessments by telemedicine and without a regulated health professional present.
- With Ministry support, the College of Physicians and Surgeons of BC and the BC College of Nurses and Midwives have temporarily revised their standards so that:
    - The limit allowing only one practitioner to conduct a telemedicine assessment is temporarily rescinded. Both practitioners can conduct the assessment by telemedicine. Telemedicine assessments must still meet the requirements set out in federal legislation as well as the standards and expectations that apply to in-person assessments.

- The requirement for a regulated health professional to act as a witness is temporarily rescinded. No witness is required for a telemedicine assessment if they are not reasonably available.

Return of Unused MAiD Medications

- Under the current provincial MAiD practice standards, "the practitioner is responsible for returning to the pharmacy any unused substances as soon as reasonably practicable, within 72 hours of confirmation of the patient's death".
- Practitioners expressed concerns that they had limited capacity due to an increasing caseload of non-MAiD patients and may need to delegate the return of substances to another health professional for return to the pharmacy.
- With Ministry support, the College of Physicians and Surgeons of BC and the BC College of Nurses and Midwives have temporarily revised their standard so that:
  - The requirement of a nurse practitioner or physician not to delegate or assign the return of MAiD substances is temporarily rescinded. When there are no other reasonable options, the nurse practitioner or physician may ask another physician, nurse practitioner, licensed practical nurse, registered nurse, registered psychiatric nurse, or pharmacist to return the substances to the pharmacy.
  - The nurse practitioner or physician must document the name of the person assigned to return the substances in the client record.

Drug Shortages

Effective May 5, 2020, and for the duration of the COVID-19 public health emergency in BC, the Bylaws of the College of Pharmacists of BC made under the authority of the *Health Professions Act* are temporarily amended so that if there is a shortage of medication for MAiD, a pharmacist may accept the return to inventory of drugs dispensed for the purpose of providing MAiD as follows:

- The medication has not left the possession of the prescribing medical practitioner or nurse practitioner, or a licensed health care professional assigned by the physician or nurse practitioner; and the integrity of the medication can be verified;
- Each dose is unused and in the original sealed tamper proof kit; and,
- The medication has been maintained in accordance with the manufacturer's requirements and any other applicable requirements.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 2, 2021 – Teri Collins, ADM, Health Services Division

February 3, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Medical Assistance in Dying

### TOPIC

- In 2016, federal legislation amended the *Criminal Code* to allow and regulate the provision of Medical Assistance in Dying (MAiD) across Canada to people who meet all eligibility criteria in accordance with specified safeguards.
- On March 17, 2021, the federal government passed Bill C-7, *An Act to Amend the Criminal Code* (medical assistance in dying).

### CURRENT SITUATION

- Between January 1, 2016 and December 31, 2020, there were 4,674 medically assisted deaths in BC,[1] representing 2.4% of all deaths in BC.[2]
- In 2020, there were 1,572 medically assisted deaths in BC representing 3.8% of all deaths in BC: 573 in the Vancouver Island Health Authority; 343 in Interior Health Authority; 256 in Fraser Health Authority; 65 in Northern Health Authority; and 335 in Vancouver Coastal Health Authority.
- Between November 1, 2018 and December 31, 2020, the average age of those receiving MAiD in BC was 76; 49% were male and 51% were female. The most common underlying condition was cancer.
- 25% of MAiD provisions in BC happened in hospital, 47% happened in the patient's home, 9% happened in hospice, and 8% happened in palliative care facilities (including hospital based palliative care beds/units).
- 75% of patients in BC received palliative care prior to receiving MAiD.

### KEY FACTS

- Effective October 31, 2018, the Ministry of Health became the designated recipient of reportable MAiD information from physicians, nurse practitioners and pharmacists, and is responsible for submitting this information to Statistics Canada on a quarterly basis. Reporting to the Ministry meets all provincial and federal reporting obligations for physicians, nurse practitioners and pharmacists.
- Health Canada released its First Annual Report on Medical Assistance in Dying on July 24, 2020, which includes new Canadian data obtained from Nov 1, 2018 – Dec 31, 2019. This is the first annual report to be produced under the federal Regulations for the Monitoring of Medical Assistance Dying, which detail enhanced data collection requirements for the provinces and territories.

Access to MAiD

- 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 patients who choose to exercise their right to MAID.
- To be eligible to receive MAiD, a person must be eligible for health services in Canada, be at least 18 years of age, be making a voluntary request, give informed consent, and have a grievous and irremediable medical condition.
- The federal legislation legally allows doctors and nurse practitioners to provide MAiD and pharmacists to dispense drugs for use in the provision of MAiD.
- Each health authority has a MAiD care coordination service which helps patients and health care providers access services.
- Federal legislation states 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 nurse practitioner chooses not to provide MAiD, patients can expect to be treated with respect and be provided with an effective transfer of care to another practitioner who is willing to provide the service.
- Ministry policy states that patients in non-denominational facilities run by contracted organizations who have more than 50% of their beds funded by the health authority must allow access to MAiD. Faith-based organizations who are a party to the Master Agreement with the Denominational Health Care Facilities

[1] Source: Medical Assistance in Dying Oversight Unit (Ministry of Health) raw data. All data is from this source unless otherwise specified.
[2] Source: Medical Assistance in Dying Oversight Unit raw data and Vital Statistics BC.

Association or declare in their constitution that they are based on religion or spirituality may decide not to allow the provision of MAiD.

BC Standards for the Provision of MAiD

- BC has professional standards for MAiD through the applicable regulatory colleges (physicians, nurse practitioners and pharmacists) that align with each other, the federal legislation and reporting regulations.
- These standards include safeguards to ensure that: a) the MAiD provider must remain with the patient during practitioner-administered or self-administered MAiD; b) only one assessment takes place via telemedicine and with a registered health professional as a witness; and c) there are standardized MAiD drug protocols and a protective chain of custody for the drugs – from the dispensing pharmacy through to the return of unused medications by the MAiD provider.
- In response to the COVID-19 public health emergency, temporary changes to process and professional standards went into effect in March 2020 (see MAiD – Temporary Process, Regulatory Practice Standard Changes and Drug Shortages During COVID-19 fact sheet).

Current Status of Federal Legislation

- On March 17, 2021, after 4 extensions from the Quebec Superior Court following its determination in the *Truchon* judgement that the eligibility criterion of a "reasonably foreseeable natural death" was unconstitutional, the federal government passed Bill C-7, *An Act to Amend the Criminal Code*.
- This new legislation expands eligibility for MAiD, modifies existing safeguards, adds new safeguards, introduces a waiver of final consent to receive MAiD in certain circumstances, and expands the monitoring regime for MAiD.
- Patients no longer must have a reasonably foreseeable death to be eligible for MAiD. There are now 2 sets of safeguards in place: one for those whose death is reasonably foreseeable, and one for those whose death is not reasonably foreseeable.
- Patients with a reasonably foreseeable death, who have been assessed and approved for MAiD, but risk losing the capacity to consent prior to provision of MAiD, will be able to sign a waiver of final consent.
- The new federal legislation includes a 2-year mental illness exclusion. During that time, the federal government will hear from experts and develop safeguards and protocols for people who seek access to MAiD, but whose sole underlying medical condition is a mental illness.
- In advance of the new legislation coming into effect, the MAiD Oversight Unit worked with stakeholders to prepare for the implementation of the new federal legislation in BC.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

April 26, 2021 – Teri Collins, ADM, Health Services Division

May 11, 2021 – H. Richards obo Martin Wright, ADM, Health Sector Information, Analysis & Planning & Reporting Division

# LEGISLATIVE SESSION - FACT SHEET

## Mental Health and Substance Use and COVID-19

### TOPIC

In March 2020, BC declared a public health emergency in response to the global coronavirus (COVID-19) pandemic. The pandemic has impacted all aspects of health care, including mental health and substance use services (MHSU), and compounded the challenges associated with BC's ongoing illicit drug toxicity crisis.

### CURRENT SITUATION

- The Ministry of Health's MHSU branch continues to support many initiatives by enabling and enhancing MHSU services in the context of the dual public health emergencies
- The COVID-19 pandemic has increased levels of stress, anxiety, depression and other mental health challenges for many people, including youth, adults, seniors, caregivers and front-line and essential workers. Specifically, in the early months of the pandemic, anxiety levels quadrupled, and depression levels doubled.[1]
- Following the COVID-19 pandemic, the public health emergency related to overdose deaths in BC, declared in April 2016, escalated signficantly due to an increasingly toxic and unpredictable illicit drug supply.
- In 2020, there were 1,716 suspected illicit drug toxicity deaths. This represents a 74% increase over the number of deaths seen in 2019, and is the highest on record.[2]

### KEY FACTS

Virtual Mental Health

- Services were expanded to support British Columbians of all ages, including health care workers, youth, students and educators, parents, seniors, victims of family of sexual violence and Indigenous Peoples.[3]
- Virtual Mental Health supports for everyone include the BounceBack program, virtual counselling, online peer support and system navigation assistance, and psychological support tools and programs and support for Front line workers, Care to Speak: peer support for BC healthcare workers and Care for Caregivers: mental health support for healthcare providers.

Child and Youth Mental Health Substance Use (CYMHSU)

In response to COVID-19, CYMHSU services have continued to expand virtual service delivery including:

- The Province supported an accelerated launch of Foundry Virtual in April 2020 by offering virtual counselling and peer support sessions to start, with services now expanded to include the full scope of Foundry's model. Demand has risen steadily since April, reaching 273 unique youth through 426 visits in December 2020. A further increase in demand is anticipated with the launch of a dedicated mobile app and browser interface in February 2021.
- YMCA's Y Mind programs quickly transitioned to offering their sessions virtually, in which young people aged 13-30 participate in 6-7 week-long virtual mental health and mindfulness programs at no cost. Initial feedback indicates the benefits of online delivery during COVID-19, including increased access to services and decreased experience of social isolation.

Adult Mental Health

- Expanded adult mental health supports include virtual delivery of no and low-cost community counselling, bc211: Safe Seniors, Strong Communities program and referral service for seniors, Mobile Response Teams supporting the mental wellness of frontline health-care workers, and free psychological first aid (COVID-19 Psychological Support Service).
- Funding through Community Action Initiative Society of BC's Community Counseling Fund was made available to scale up virtual services for an additional 20 organizations. Initial reporting showed that 94% (17 of 18) of organizations saw an increase in demand for counselling services as a result of COVID-19.

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[1] Mental Health Research Canada. (May 2020). Mental Health During COVID-19 Outbreak: Wave 1. https://static1.squarespace.com/static/5f31a311d93d0f2e28aaf04a/t/5fb547325fd88c0dffc87360/1605715765135/MHRC+Covid+Poll+3+Presentation+-+Public+Release+Final.pdf

[2] BC Coroner's Service (2020) Illicit Drug Toxicity Deaths in BC January 1, 2010 – December 31, 2020. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

[3] Virtual mental health supports during COVID-19. https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/virtual-supports-covid-19

Pharmaceutical Alternatives to the Toxic Illicit Drug Supply

- On March 26, 2020, the Ministry and BC Centre on Substance Use (BCCSU) released the *Interim Clinical Guidance for Risk Mitigation in the Context of Dual Public Health Emergencies* to support individuals at risk of substance use-related harms exacerbated by the COVID-19 pandemic by improving access to prescribed pharmaceutical alternatives to illicit drugs.
- In September 2020, the Ministry, Ministry of Mental Health and Addictions (MMHA) and Office of the Provincial Health Officer (PHO) expanded access to pharmaceutical alternatives and issued a PHO order enabling registered nurses and registered psychiatric nurses to prescribe these medication, beginning with Suboxone™. The order aims to reduce overdoses by reducing peoples' reliance on the illicit drug supply, and improve access to ongoing care, treatment and support.[4] [5]

Overdose Prevention Services

- In collaboration with ministries, health authorities and the BCCSU, BC's Overdose Emergency Response Centre developed a protocol to guide health and social service agency staff who observe or encounter people who require episodic overdose prevention services which are provided outside of established supervised consumption/overdose prevention services, including acute care hospitals.
- In May/June 2020 the Provincial Health Services Authority launched Lifeguard, a mobile app that can connect people who use drugs alone to first responders if an overdose occurs.

Supportive Recovery Services

- Supportive recovery homes have staggered resident admissions and limited room occupancy to allow for quarantine periods and physical distancing. This has decreased service capacity.
- Bed-based treatment and recovery services have also increased their cleaning protocols and implemented the use of personal protective equipment to mitigate risks to both clients and staff.
- In April 2020, the Province issued *Interim Guidance to Social Service Providers for the Prevention and Control of COVID-19 in their Facilities* to help operators prevent the spread of COVID-19.

Emergency Response Centres and Temporary Shelters for people experiencing homelessness

- On April 16, 2020, the Ministry, Ministry of Municipal Affairs and Housing and BC Housing released *COVID-19: Joint Provincial Program Framework for Emergency Response Centre*s which provides overarching guidance for establishment of Emergency Response Centres during COVID-19 to facilitate physical distancing and reduce risk of COVID-19 transmission for people who are experiencing or who are at risk of homelessness and are unable to self-isolate.
- In response to the COVID-19 pandemic, the Province has transitioned people experiencing homelessness and living in encampments into temporary safe accommodation, including Emergency Response Centres, and continues to collaborate with partners to explore cross-sector policy options and approaches to support people with mental health or substance use issues that are transitioning from homelessness.

## FINANCIAL IMPLICATIONS

- In April 2020, MMHA announced $5.0 million in one-time funding to expand access to virtual mental health services and resources for British Columbians facing mental health challenges during COVID-19.
- In July 2020, MMHA announced $2.5 million in new funding to support operators of existing bed-based treatment and recovery services that have experienced financial challenges as a result of COVID-19.
- In 2020/21, the Ministry provided the regional health authorities with additional one-time funding of $10.5 million to accelerate access to overdose prevention services, pharmaceutical alternatives to the illicit drug supply and expand outreach teams.

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**Approved:**

February 12, 2021 – Teri Collins, ADM, Health Services Division
March 1, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
March 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
March 8, 2021 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division

[4] MMHA News (2020, September 16). Retrieved from: https://news.gov.bc.ca/releases/2020MMHA0051-001754
[5] For more information, please refer to the Pharmaceutical Alternatives to Illicit Street Drugs fact sheet

# LEGISLATIVE SESSION - FACT SHEET

## Nursing Support Services Program

### TOPIC

Nursing Support Services (NSS) is a provincial program operated by the Provincial Health Services Authority (PHSA) that provides care where the knowledge, judgement and skill of a licensed nurse is required in order for children and youth (0-19) with chronic, complex medical conditions and their parents and caregivers to lead active, healthy lives in their communities.

### CURRENT SITUATION

- Currently 232 children and youth are receiving In-home Nursing Respite Care and 1,100 children are receiving Delegated Nursing Care (in school, preschool and child-care settings)[1].
- In-home Nursing Respite Care was affected by COVID-19 due to isolated staffing shortages and families suspending/reducing services; however, these issues have been addressed.

Advice/Recommentations

### KEY FACTS

- A range of specialized support is available to assist families with children who have unique and complex health care needs. The NSS program includes:
  - **In-home Nursing Respite Care** - Provides scheduled, intermittent breaks for families/guardians from the day-to-day medical care needs of their child/youth with fragile and complex medical conditions when the knowledge, judgement and skill of a licensed nurse is required. In-home Nursing Respite Care may provide support for eligible children to attend school or preschool.
  - **Delegated Nursing Care** - Training and ongoing monitoring of unregulated caregivers in school, preschool and child-care settings to provide special 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 BC College of Nurses and Midwives practice standard for delegation.
- The NSS program was transferred from MCFD to the Ministry of Health (MoH) effective April 1, 2015. PHSA is responsible for NSS program delivery through BC Children's Hospital. The program works with NSS coordinators (RNs) in regional health authorities to provide NSS. NSS also conducts At Home Program assessments on behalf of MCFD.
- Children and youth who receive In-home Nursing Respite Care are among the most medically fragile in the province. Many require care 24 hours a day, 7 days a week by an alert parent or nurse. NSS does not have a wait list.
- NSS In-home Nursing Respite Care is intended to provide parents with planned 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) is available. The current program average is 42 hours per week.
- Since 2011, it was MCFD practice to fund additional nursing care hours for medically fragile children based on specific family needs. These hours were above the NSS program maximum for In-home Nursing Respite clients although there was not a program base budget, policy or expertise to evaluate need. PHSA previously estimated that 30%[2] of In-home Nursing Respite Care clients receive some form of additional support from MCFD, which sometimes includes non-nursing care. MCFD provides additional support through the same nursing agencies contracted by PHSA and/or through funds directly to families to purchase services privately.

[1] Communication from NSS Program, PHSA, February 5, 2021

[2] MCFD has indicated a shift in this practice and the actual figure may be lower.

- In 2018, MCFD asked the MoH to review the framework in which in-home nursing respite care is provided.
- Since the program transfer from MCFD, NSS has maintained services for families receiving In-home Nursing Respite Care while also identifying areas of improvement related to safety, quality of care, competency/training, value for money and best practice. PHSA previously developed a business case based on this work and submitted to MoH, MCFD and PHSA senior executive. PHSA is redeveloping this work in the context of business planning for the Slocan site redevelopment project.
- Discussions between MCFD and PHSA are underway to collaboratively determine the best approach for smooth transitions for children as their care needs change that ensures continuity of services for families.
- In May 2019, a group called BC Parents of Complex Kids sent the report *Recommendations for Nursing Support Services (PHSA) in British Columbia* to several individuals and organizations, including the Minister of Health and the Office of the Representative of Children and Youth. The document calls for changes to the NSS program.
- In September 2019, BC Children's Hospital met with representatives from BC Parents of Complex Kids to review the recommendations from their report. A subsequent meeting was held on February 3, 2021 and plans are underway to explore the formation of an advisory table to continue to strengthen relationships and collaboration. Representatives of this group are engaged in providing feedback on the Slocan site redevelopment project through the Family Advisory Committee.
- MCFD is developing a new Children and Youth with Support Needs (CYSN) Service Framework to better support CYSN and their families. MCFD has opened applications for positions on a Minister's Advisory Council on CYSN to begin meeting Spring 2021 that will provide a forum to build relationships, discuss issues related to planning and delivery of CYSN services and provide advice on new CYSN service model and how to implement the new framework.

In-Home Nursing Respite Care Program Model

- NSS has contracts with three agencies to provide NSS in-home nursing respite for April 1, 2019 to March 31, 2022.
- The NSS program directly manages the nursing service contracts, providing provincial oversight to ensure the quality and competency of nursing services for medically fragile children.
- PHSA developed and implemented a standardized centralized referral and intake process and a standardized annual reassessment process; all children are expected to be reassessed at least annually.
- PHSA developed a draft eligibility and service level framework that covers the needs of children/families and ensures coordination with MCFD non-nursing respite supports. Algorithms to support the eligibility and service level framework were initiated in 2019 and piloted in the Fraser Health region. This has been delayed by the COVID-19 pandemic and further evaluation is anticipated in the coming months.

## FINANCIAL IMPLICATIONS

- NSS program funding was transferred from MCFD to MoH effective April 1, 2015.

Government Financial Information

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**Approved:**
February 24, 2021 – Teri Collins, ADM, Health Services Division
March 4, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Office of the Auditor General Report – Access to Emergency Health Services

### TOPIC

The 2019 Office of the Auditor General (OAG) report *Access to Emergency Health Services* found that BC Emergency Health Services (BCEHS) effectively manages access to ambulance and emergency health services in some areas but there are key areas for improvement and coordination with fire departments that need to be strengthened.

### CURRENT SITUATION

- Response to the COVID-19 pandemic required the Ministry of Health and BCEHS to temporarily put work to implement the OAG report recommendations on hold, impacting the time commitments made in February 2020.
- The Ministry notified the Office of the Comptroller General, the OAG and Select Standing Committee on Public Accounts (PAC) of the delay in May 2020. It is expected the next update to PAC will be in September 2021.
- While this work was on hold, the Pre-Hospital Care Collaborative Committee was formed in April 2020 and has been working collaboratively to provide evidence-informed opinions and expert guidance to support the ongoing COVID-19 pandemic response, as it relates to multi-agency response to emergency medical events in the pre-hospital environment.
- The Committee includes representation from the Ministry, the Office of the Provincial Health Officer (PHO), Provincial Health Services Authority, BCEHS, Fire Chiefs Association of BC, Office of the Fire Commissioner, the Local Government Management Association (rural and urban ), rural and urban fire chiefs, and Patient Voices Network.
- The Committee has successfully worked through fire first responder dispatch changes related to the COVID-19 response and has been actively monitoring COVID-19 rates and first responder exposures. The Committee developed a data monitoring tool including the availability of PPE supplies, exposure events, first responder notification data, daily COVID-19 case data, WorkSafe BC data, and daily COVID-19 hospitalization data. This work has helped build relationships and dialogue that will directly impact fulfilling the four recommendations of the OAG Report.
- Tangible actions to manage the response to emergency health calls, in the context of COVID-19, included:
    - On March 25, 2020, direction was provided by the PHO to reduce the amount and type of 911 calls that Fire First Responders were historically dispatched.
    - Following the recommendation of the Committee, an addendum was made in April 2020, in which fire first responders were dispatched to all red overdose calls.
    - On the advice of the Committee, in September 2020 the PHO also enabled rural and remote first responders to again attend the less urgent but still serious “orange” coded calls they had previously attended. This continues to be monitored closely by the Committee.
- The Committee has now resumed work on the OAG Report recommendations and has established 3 working groups focussed on medical oversight, data sharing, and ensuring appropriate level of response.

### KEY FACTS

- In the 2019 Report, the OAG made 4 recommendations; the first 3 were accepted by BCEHS and the fourth by the Ministry: to work with local governments and BCEHS to ensure that BCEHS can implement a coordinated approach to pre-hospital care.
- Prior to the onset of the COVID-19 pandemic, the Ministry and BCEHS were meeting regularly to address recommendation four, which included developing a plan to consult with local governments.
- The Ministry and BCEHS presented to the Select Standing Committee on Public Accounts (PAC) on April 23, 2019 with a follow up meeting on October 17, 2019.
- The Ministry and BCEHS presented at the UBCM conference in September 2019 and presented to Rural Area Directors in February 2020.

- The Ministry and BCEHS developed an Action Plan and Assessment (APPA) which outlined progress to achieve Report recommendations. It was submitted to, and accepted by, the PAC in February 2020.
- Based on feedback from UBCM participants and other stakeholders, BCEHS had developed a discussion paper, which was intended to help develop the final collaboration agreement framework document (to fulfill recommendation four). This paper will be updated as noted below.
- The Ministry and BCEHS were planning the share the draft discussion paper with stakeholders just prior to the pandemic. The Committee now plans to review the discussion paper and update the content to reflect the new relationships and the collaborative work that has taken place since the beginning of the pandemic.
- The following progress on the OAG report recommendations as of May 2021 has been made:
  1. BCEHS review its performance management framework to identify additional indicators for timeliness and clinical quality. **Progress Assessment:** Complete.
     - A new performance management framework was completed and continues to be used by BCEHS. Eleven indicators have been adopted to reflect timeliness and clinical quality across all aspects of BCEHS operations.
  2. BCEHS determine an appropriate level of pre-hospital advanced care coverage that considers patient need and implement strategies to achieve that level. **Progress Assessment:** Substantially Implemented.
     - In 2018, BCEHS created a new role for Advanced Care Paramedics (ACPs) in rural communities. In spring 2020, as part of the COVID-19 response, BCEHS deployed 16 ACPs in communities across the province.
     - In alignment with the Rural, Remote, First Nations, and Indigenous COVID-19 Response Framework, BCEHS deployed 55 additional ground ambulances and 5 air ambulances.
     - A long-term sustainment strategy for those resources will be completed by July 31st, 2021.
  3. That BCEHS improve transparency and accountability by publicly reporting on its targets and performance. **Progress Assessment:** Substantially implemented but progress to complete this has been delayed due to COVID-19 operational priorities.
     - BCEHS will regularly post progress on key initiatives and performance measures by July 31, 2021.
  4. The Ministry work with local governments and BCEHS to ensure that BCEHS can implement a coordinated approach to pre-hospital care. **Progress Assessment**: Substantially implemented but progress to complete this has been delayed due to COVID-19 operational priorities.
     - A policy paper was drafted in Spring 2020 and will be updated as work re-starts.
     - The Ministry, through work with Committee, will develop a municipal engagement plan by May 31, 2021, pending external partners ability to contribute (fire chiefs, Local Government Management Association, etc.).
     - The Ministry, through the work with the Committee, will develop and propose appropriate models to support a coordinated approach to responding to calls and medical oversight by July 31, 2021.
     - Following consultation, the BCEHS will revise and update municipal consent and collaboration agreement templates including data sharing agreements by January 31, 2022.
     - Following consultation, EHS will have data sharing framework in place in the lower mainland by fall, 2021.
     - The Ministry, with BCEHS, will engage with municipalities through 2022, to complete consent and collaboration agreements (including data sharing agreements). Pending advice from municipal partners, this work will begin with those municipalities where no existing agreement exists followed by a refreshed agreement for the others.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Office of the Seniors' Advocate Report on Long-Term Care Funding

### TOPIC

- On February 4, 2020, the Office of the Seniors Advocate (OSA) released a report titled *A Billion Reasons to Care: A Funding Review of Contracted Long-Term Care in BC*, which was the first provincial review of the contracted long-term care (LTC) sector completed by the OSA.[1]
- The report examined 174 contracted LTC homes[2] 2016/17 and 2017/18 financial statements and expense reports submitted to health authorities (HAs) by LTC home operators.
- Several differences in approach to financial expenditures were identified between for-profit and non-profit homes when comparing spending on direct care hours, building costs, overall profits and surplus, employee wage costs, and financial transparency.

### CURRENT SITUATION

- In the report, the OSA put forward 5 recommendations:
    - funding for direct care must be spent on direct care;
    - monitoring for compliance with funded care hours must be more accurate;
    - define which aspects of LTC home operation can make profits;
    - standardize reporting for all care homes throughout B.C.; and
    - make revenues and expenditures for publicly funded care homes available to the public.
- HAs have differing internal processes to meet their regional needs, which can result in varying approaches and requirements to contract management.
- The Ministry has developed a standardized, web-based monitoring tool to collect information at the facility-level directly from LTC operators, including bed capacity, program revenues and expenses, and staffing levels.
- The monitoring tool was implemented in August 2020 and approximately 300 publicly-funded LTC homes are actively submitting information to the monitoring tool. Learnings from the implementation of the tool will inform refinements and adjustments to the tool through 2021.
- The monitoring tool will increase accountability for public funding as well as provide the foundation for development of a province-wide standardized funding model for LTC.
- The Ministry has analyzed potential funding models and cross jurisdiction comparisons that would address many of the identified issues in the Report. The Ministry has engaged experts to assist with the development of a standardized funding methodology and implementation plan.

### KEY FACTS

**According to the Report**

Funding for Long-Term Care

- Approximately $2 billion per year is spent on LTC services, with $1.3 billion in public funding going to the contracted sector and the remainder spent on HA owned and operated homes; public funding is composed of both client contributions and government sources.
- In BC, there are over 27,000 seniors living in 293 publicly funded LTC homes.[3]
- 38% of LTC homes are HA owned and operated with the remaining homes operated by contracted service providers; 34% are operated by for-profit companies and 28% are operated by not-for-profit societies.
- LTC operators enter into a financial and service contract with the HA that includes requirements for services to be delivered and levels of care to be provided.

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[1] Office of the Seniors Advocate: *A Billion Reasons to Care: A Funding Review of Contracted Long-Term Care in B.C*
Available at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2020/02/ABillionReasonsToCare.pdf

[2] Ibid

[3] OSA excludes LTC homes inclusive of younger populations or specialized populations, which results in a lower facility count compared to other sources.

- Contracted LTC operators receive block funding from the HA as a daily per diem rate per bed that is calculated by dividing the total block funding by the number of publicly funded beds in a care home and then dividing that by 365 days.
- Contracted LTC homes have varying funded per diem rates in which they are funded, ranging between $171 to $282 per bed per day, as determined in their contracts with the HAs. The variation may be a result of size of home (small homes are more costly to operate), capital costs for the building, or specialized populations).
- Contracted LTC homes are required to provide quarterly or bi-annual financial reports and annual audited financial statements to their HA. Financial statements for care homes operated by not-for-profit societies are publicly available, but for-profit operators are not obliged to make their audited financial statements available to the public. Quarterly (or bi-annual) reporting templates are not standardized between HAs.

Direct Care Hours and Staffing

- Direct care hours reported publicly by the OSA are funded direct care hours and not actual direct care hours delivered.
- When comparing revenue spent on direct care, on average, the not-for-profit operators spent 59% of their revenue on direct care compared to 49% in the for-profit sector.
- Co-located beds (beds in homes with publicly and privately funded beds sharing the same resources) may report differences in direct care hours between the two payment-type of residents. Approximately half of contracted LTC homes have private pay beds co-located with publicly subsidized beds.
- When comparing the costs of employing a health care aide per hour worked, not-for-profit care homes spent $37.20 compared to $30.23 spent by for-profit care homes. Differences are attributed to wage and benefit costs, overtime and backfill.
- The OSA suggests that part of the staffing challenges faced by some for-profit operators could be related to the lower wages being paid, on average, to employees.
- For-profit sector spent, on average, $36,691 per resident per year on direct care staffing compared to $46,236 by not-for-profit sector, a difference of approximately 24%.
- The report advocates for implementation of methods to monitor direct care hours worked in LTC homes, for the resulting data to be publicly available, and for a timely, effective, and transparent response to address operators that fail to deliver the contracted care hours.

Revenues and Profit

- For-profit and non-profit LTC homes differ on the percentage of revenue spent annually on building costs, which can include variables such as mortgages, amortization, and property depreciation; these variables can also differ between HAs.
- In 2017/18 the OSA estimated $150.4 million (20% of their annual revenue) was expensed by for-profit operators on building costs versus $58.9 million (9% of revenue) expensed by not-for-profit.
- Building costs can range between 2% to 38% of a care home's annual expenses.
- For-profit sector generated an estimated $34.4 million in profits, 12 times higher than the $2.8 million surplus estimated for not-for-profit sector.
- The OSA estimated that 18 care homes had an annual profit/surplus over $1 million during 2017/18, with 17 of those 18 homes being run by for-profit operators.

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

February 22, 2021 – Teri Collins, ADM, Health Services Division
March 4, 2021 – Kerri Harrison/Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Pharmacotherapies for Opioid Use Disorder – OAT, iOAT, TiOAT

## TOPIC

Treatment of opioid use disorder (OUD) includes the provision of medication-assisted treatment and the prescribing of pharmaceutical-grade opioid agonist medications by health care providers.

## CURRENT SITUATION

The Ministries of Health (MoH) and Mental Health and Addictions (MMHA) and the Overdose Emergency Response Centre (OERC) are working to expand access to medication-assisted treatments for OUD, including opioid agonist treatment (OAT), injectable opioid agonist treatment (iOAT), and tablet injectable opioid agonist treatment (TiOAT).

## KEY FACTS

- OUD is one of the most challenging forms of substance use disorder facing the health care system in BC, and a major driver of illicit drug toxicity deaths and the overdose public health emergency.
- The continuum of care for OUD includes pharmacological and non-pharmacological (e.g. structured psychotherapies) treatment interventions and supports, to meet individual and population needs.

Oral Opioid Agonist Treatment

- In February 2017, the BC Centre on Substance Use (BCCSU) released a provincial guideline for the clinical management of OUD, recommending OAT in the form of buprenorphine/naloxone (i.e., Suboxone®), methadone, and, slow-release oral morphine as first, second, and third line treatments for OUD.[1]
- Coverage for OAT medications is available to individuals eligible for Pharmacare's Plan G.
- In January 2021, there were 1,606 OAT prescribers across BC, a 11% increase from January 2020 (1,448). 23,965 patients received OAT in January 2021, a 3% increase from January 2020 (23,262).[2]

Injectable Opioid Agonist Treatment

- In October 2017, the BCCSU released a provincial guidance document for the use of iOAT (supervised injectable hydromorphone or diacetylmorphine) as a specialized, intensive last line treatment option for patients who do not respond successfully to oral OAT.[3]
- Currently, iOAT is available in high-need communities as determined by overdose surveillance data, including Surrey, Abbotsford, Kelowna, Victoria and multiple Vancouver locations. In December 2020, MoH and MMHA approved plans for Northern Health's first integrated iOAT and TiOAT program in Prince George. The Ministries and Health Authorities are continuing to work to expand programs where needed.

Tablet Injectable Opioid Agonist Treatment

- TiOAT is an innovative model using supervised consumption of hydromorphone tablets via oral intake and/or injection and offers greater clinical flexibility and patient autonomy than iOAT.
- In January 2019, Vancouver Coastal Health Authority (VCHA) and the Portland Hotel Society launched a 6-month TiOAT pilot program at the Molson Overdose Prevention Site in Vancouver. Preliminary TiOAT chart review findings reveal that 76% of patients remained on TiOAT from January 2019 to August 2019. Of the 24% of clients who discontinued TiOAT, 79% transitioned to traditional oral OAT. No deaths or overdoses occurred.[4]
- In response to promising pilot results and the ongoing risk of illicit drug toxicity death, MoH and MMHA approved the expansion of TiOAT to additional sites in Vancouver, Kamloops, Surrey, and Prince George.

Emerging Pharmaceutical Alternative Programs and Approaches

- MoH continues to explore and pilot other pharmaceutical alternative programs that build on medical models that require prescriptions and a degree of monitoring and care from authorized health professionals and operate within the parameters of current legislation and regulations.
- In February 2021, the BC Coroners Service reported that hydromorphone has been detected in only 3% of illicit drug toxicity deaths in the previous 6 months.[5]

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[1] Provincial Guidelines for the Clinical Management of Opioid Use Disorder. Retrieved from https://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

[2] "OAT data for BCCDC – 2021-01", OAT monthly report, PharmaNet, HSIAR, February 16, 2021

[3] Guidance for iOAT for OUD. Retrieved on Aug 31 2020: https://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf

[4] Vancouver Costal Health. (2019, September). iOAT evaluation of preliminary data.

[5] BC Coroners Services. (2020). Ilicit Drug Toxicity Type of Drug Data, data to December 13, 2020. Last Accessed February 16, 2021 from https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug-type.pdf

- In December 2019, Canada's first automatic dispensing machine pilot project launched in the VCHA region. As of March 2020, MySafe, was supporting 15 clients with hydromorphone tablets.[6] In August 2020, the pilot was expanded to one site in Victoria and an additional site in Vancouver.[7]
- In July 2020, Island Health received funding from Health Canada's Substance Use and Addictions program (SUAP) for a pilot project in the Cowichan Valley to provide pharmaceutical-grade hydromorphone as an alternative to the toxic illegal drug supply for people who have not responded to other forms of OUD treatment.[8]
- In February 2021, the Federal Government announced $15 million for 4 safer supply projects in BC that will provide pharmaceutical-grade medication as an alternative to the toxic illegal supply for individuals with OUD.[9]
- In March 2020, the Province announced interim clinical guidance [10] for health care providers to support people who use drugs during COVID-19 and the ongoing overdose emergency. Designed to mitigate risks of overdose, withdrawal, and community spread of COVID-19, the Risk Mitigation Guidance supports providers to prescribe safer pharmaceutical alternatives to toxic illegal drugs to support physical distancing or isolation as required. The outcomes of this guidance are being evaluated by a multidisciplinary team from several BC universities.
- In September 2020, the Provincial Health Officer (PHO) issued an order authorizing registered nurses and registered psychiatric nurses to prescribe OAT, beginning with buprenorphine/naloxone. This order aims to reduce overdoses by reducing peoples' reliance on the illicit drug supply, and improve access to ongoing care, treatment and support.[11] Additional medications may be made available following consultation with health system partners.
- MoH, MMHA, and the PHO are developing an updated policy directive for prescribers and health authorities, building on the existing risk mitigation clinical guidance. The new directive will expand eligibility to prioritize reducing overdose risk; carefully expand the types of medications by leveraging existing health authority clinical settings ; and emphasize continued commitment to evaluation, monitoring, and evidence-based care planning.

## FINANCIAL IMPLICATIONS

- Through Budget 2017 Update and Budget 2019, the Government has committed $469.4 million over 4 years (2017/18 to 2020/21) towards the Provincial Overdose Emergency Response:
    - $390.3 million for the MoH
    - $44.1 million for the Ministry of Public Safety and Solicitor General
    - $35.0 million for the MMHA
- As part of the Provincial Emergency Overdose Response, MoH has allocated (2017/18 to 2020/21):
    - $18.1 million to the VCHA for current iOAT.
    - $14.8 million to Fraser Health Authority, VCHA, and Providence Health Care's iOAT expansions.
    - $13.3 million to PHSA to support OAT in correctional facilities.
    - $0.86 million to support PhamaCare's current iOAT programs.
    - $0.82 million to support PharmaCare's Pharmacist OAT training.
- The Federal Government has committed $188.4 million over 4 years (2017/18 to 2020/21) to the Province to support the Emergency Overdose Response through the *Canada-British Columbia Home and Community Care and Mental Health and Addictions Services Funding Agreement*.
    - MoH has allocated $23.3 million of this funding to increase iOAT.
- The Federal Government has committed an additional $33.98 million to the Province over 3 years (2018/19 to 2020/21) to support the Overdose Response through the *Canada-British Columbia Emergency Treatment Fund Bilateral Agreement*.
    - $2.0 million has been notionally allocated on a one-time basis for iOAT expansion in 2021/22.

[6] Medscape Medical News. (2020, March 04). Retrieved from https://www.medscape.com/viewarticle/926231
[7] Victoria News. (2020, August 24). Retrieved from: https://www.vicnews.com/news/victoria-ready-to-welcome-drug-dispensing-machine-to-fight-opioid-crisis/
[8] MMHA News. (2020, July 15). Retrieved from: https://news.gov.bc.ca/stories/government-of-canada-supports-safer-supply-pilot-project-in-bc
[9] Health Canada. (2021, February 2). https://www.canada.ca/en/health-canada/news/2021/02/government-of-canada-supports-four-safer-drug-supply-projects-in-british-columbia.html
[10] https://www.BCCDC.ca/overview-covid-19-risk-mitigation-interim-clinical-guidance/
[11] MMHA News (2020, September 16). Retrieved from: https://news.gov.bc.ca/releases/2020MMHA0051-001754

- In 2020/21, the Government provided an additional $10.5 million to further accelerate the response to an increasingly toxic illicit drug supply due to COVID-19, including expanding access to pharmaceutical alternatives.

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**Approved:**
April 28, 2021 – Ross Hayward obo Teri Collins, ADM, Health Services Division
May 7, 2021 – Christine Voggenreiter obo ADM Martin Wright, Health Sector Information, Analysis & Reporting Division
May 10, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Rural and Remote COVID-19 Response Framework

## TOPIC

Announced by the Premier in April 2020, the Rural, Remote, First Nations and Indigenous COVID-19 Response Framework was developed to help ensure people living in rural, remote and Indigenous communities have access to critical health care to meet their unique needs during the COVID-19 pandemic and into the future.

## CURRENT SITUATION

The Framework continues to support rural, remote and Indigenous communities through the COVID-19 pandemic. Planning for the longer term strategies to support these communities beyond the pandemic is underway.

## KEY FACTS

- The Framework was developed through a partnership between the First Nations Health Authority (FNHA), Northern Health Authority (NHA) and the Provincial Health Services Authority (PHSA).
- The Framework is intended to bring both immediate and long-term, sustainable solutions to those living in rural and remote communities. It addresses the persistent social and health inequities that Indigenous communities and people experience.
- The Framework's guiding principles include flexibility, informed choice, evidence-based decision making, collaboration, geography, community networks, local context, First Nations entitlements and rights, and culturally safe and collaborative dialogue.

**Progress against Key Deliverables**

**Improvements to Service Delivery**

- FNHA's Virtual Doctor of the Day (primary care), Virtual Substance Use/Addiction Medicine and Virtual Psychiatry brings care closer to home for First Nations people and their families.
- HealthLink BC Emergency iDoctor-in-assistance-virtual emergency physician support for 8-1-1.
- ~24,000 Zoom licenses were issued to family and specialist physicians and nurse practitioners. Real-time support pathways established to support rural providers 24/7 in: emergency medicine, critical care, pediatrics, maternity and newborn. Non-acute support is available for dermatology, chronic pain treatment, rheumatology, clinical hematology and thrombosis medicine .

**Community Cohort Centres (CCCs)**

CCCs have been established near acute care sites in 18 communities to provide safe accommodation and wrap-around supports for patients who wish to isolate near acute and critical care should their health deteriorate. The communities are: Cranbrook, Trail, Kelowna, Penticton, Kamloops, Vernon, Williams Lake, Terrace, Prince George, Fort St. John, Victoria, Nanaimo, Campbell River, North Vancouver, Vancouver, Abbotsford, Chilliwack and Hope.

**Clinical Pathways**

- Clinical pathways for informed decisions, testing, and self-isolation were iteratively co-developed between health authorities (HAs) and partners. Regional HAs, FNHA and BC Emergency Health Services (BCEHS) have shared with relevant clinical teams.
- The Ministry approved funding for FNHA to allocate 97 community liaison positions to support culturally safe contact tracing and bring community and health system expertise.

**Rural Laboratory Services Strategy**

- The testing strategy leverages the network of hospitals in BC to ensure that no region is overwhelmed by testing demand.
- Small, rapid-access testing platforms have been deployed to/in rural sites:
  - GeneXpert analyzers are in place in Kamloops, Kelowna, Cranbrook, Trail, Victoria, Port McNeill, Prince George, Terrace, Fort St. John, Sechelt, Powell River, Kwadacha (Fort Ware), Nuu-Chah-Nulth Tribal Council (Tofino), Ulkatcho (Anahim Lake), Comox, Nanaimo, Port McNeil, Kwakiutl District Council (Campbell River), Bella Bella and Bella Coola.
  - Biofire Analyzers are in place in hospitals in Bella Coola, Bella Bella, Kamloops, Kelowna, Cranbrook, Trail, Prince George, Terrace and Fort St. John.

- Rapid point-of-care tests (Abbott ID Now, Panbio, BD Veritor) have been distributed to FNHA and regional HAs and are being used in rural, remote and Indigenous communities, outbreak settings and where appropriate as directed by Medical Health Officers.

**Transportation**

- BCEHS has implemented a Surge Plan, which includes 55 additional ground and five additional air ambulance resources allocated, deployed and staffed to support rural and remote communities. The surge plan was developed by BCEHS with partnership of all regional HAs and FNHA.
- Advanced Care Paramedics have been deployed in Whistler, Campbell River, Vernon, Trail, Cranbrook, Penticton and Fort St. John. Recruitment is underway in Terrace and for one position in Fort. St. John.
- BCEHS created a major incident rapid response team (MIRRT) of specialized paramedics that can be deployed to support local paramedics and HAs, if requested, in communities experiencing significant surges in COVID-19. To date, MIRRT has been deployed to Fort St. James,Williams Lake, and Terrace
- The Ministry, BCEHS and NHA have made improvements to transfers, such as:
  - Implementing a no-refusal policy at Mills Memorial Hospital (Terrace) and the University Hospital of Northern BC (Prince George) for patient transfers from certain rural and remote locations, allowing BCEHS to begin the transfer process without waiting for agreement from the receiving site/physician.
  - Implementing a 24/7 escalation process when a patient needs to be transferred out of a challenging (e.g. limited services, difficult geography) rural or remote location.
- BCEHS has developed a contingency plan for BC residents on the eastern border if Alberta exceeds their capacity to assist in the transport and care of the most urgent cases (as is current practice).

**Community Self-Isolation Centres**

- A menu of in-community self-isolation options have been developed to provide each community with choice. HAs and FNHA continue to engage their communities to determine best options.
- Despite facing some challenges in establishing in community isolation options, all HAs are ready to meet communities where they are at to best support patients in community with pathways to access accommodation, clinical, social and cultural supports in a timely manner.

Background

- Nearly 95% of BC's land base is non-urban.[1] Rural and remote populations have historically struggled with equitable access to care and transport. COVID-19 has increased these challenges.
- Indigenous peoples comprise approximately 200,000 people in BC. There are 203 distinct First Nations in BC, each with their own unique traditions and history. More than 30 different First Nations languages and close to 60 dialects are spoken in the province.[2]
- The need for access to acute and ventilated care in critical cases can happen rapidly. Transporting patients to support their changing needs in a rural and remote environment can be very challenging.

## FINANCIAL IMPLICATIONS

- The Ministry provided funding of approximately $21 million in 2020/21 to support the BCEHS component of the Province's new rural, remote collaborative framework.
- Up to approximately $48.2 million in 2020/21 has been allocated to support virtual emergency physician services, virtual care teams in regional HAs and PHSA and isolation/community supports being managed through the FNHA.
- Budget 2021 has allocated up to $900 million from the Pandemic and Recovery Contingencies to address health sector needs including maintaining a number of new health strategies such as the Rural and Remote Collaborative Framework.

**Approved:**

May 7, 2021 – Teri Collins, ADM, Health Services Division

May 26, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] Ministry of Health. (2015). *Rural health services in BC: A policy framework to provide a system of quality care.* (p. 13). Retrieved from https://www.health.gov.bc.ca/library/publications/year/2015_a/rural-health-policy-paper.pdf. Last accessed on October 7, 2020.

[2] WelcomeBC. (n.d.). *B.C First Nations & Indigenous People*. Retrieved from https://www.welcomebc.ca/Choose-B-C/Explore-British-Columbia/B-C-First-Nations-Indigenous-People. Last accessed on October 7, 2020.

# LEGISLATIVE SESSION - FACT SHEET

## Safe Seniors Strong Communities (bc211 Expansion)

### TOPIC

- Safe Seniors, Strong Communities (SSSC) was developed collaboratively by the Ministry of Health, the United Way of the Lower Mainland (UWLM), and bc211 in March 2020 in response to the COVID-19 pandemic.
- The program matches community-based seniors whose regular support network has been disrupted by the pandemic, or whose need for support has increased as they self-isolate, with local volunteers to provide non-medical services.

### CURRENT SITUATION

- The SSSC launched on March 26, 2020. As of March 30, 2021, there were 25,483 seniors and 13,393 volunteers registered to participate in the program, with 816,457 total services provided as follows:
  - 354,480 wellness visits
  - 70,462 grocery deliveries
  - 240,223 meals prepared or packaged and delivered
  - 1,753 prescriptions picked up and delivered
  - 149,539 other services
- SSSC data is inclusive of Better at Home (BH) service data. The expedited roll out of SSSC at the start of the COVID-19 pandemic put emphasis on service delivery to meet the immediate needs of BC seniors. SSSC used existing BH program structures and reporting processes, and all program data collection was rolled together. Independent SSSC data collection has started for 2021/22 (for more information about BH, see Better at Home Fact Sheet).
- The program is active and is contemplated to continue for the duration of the COVID-19 pandemic.

### KEY FACTS

- The program was developed by leveraging existing programs through the United Way (primarily the BH program) to ensure the fastest possible mobilization. bc211, a web and telephone service that refers clients to a variety of government and non-government service agencies, was engaged as the intake method for both volunteers and seniors in need. Previous to COVID-19, bc211 was geographically limited to the Lower Mainland and Vancouver Island; as part of the Safe Seniors initiative, bc211 was expanded to provide provincial coverage.
- bc211 refers volunteers and seniors to regional BH HUB agencies. Matching seniors with volunteers happen at the HUB agency or through other United Way or non-United Way agencies.
- Seniors are assessed at intake, and those deemed to be at-risk are prioritized to ensure assistance within 24 hours, while other seniors received assistance within 72 hours.
- The Ministry receives regular activity reports from bc211 and UWLM and will continue to monitor volumes and performance for the duration of the program.

### FINANCIAL IMPLICATIONS

- In 2019/20, the Ministry provided Government ($50 million announced, Government Financial Information to the UWLM to support its programs, including support for and expansion of the BH program.Government Financial Government Financial Information

Governme COVID-19 Response funding flows through the UWLM to other United Way and non-United Way agencies across the province.

Government Financial Information

Government Financial Information

- The initial costs associated with improvements to the bc211 website were absorbed by the Ministry of Citizen Services (CITZ), and CITZ staff leveraged Government's relationship with Telus to minimize the financial impact for the required increase to call center capacity. By leveraging the *Telecommunications Services Master Agreement* pricing and resources, staff were able to mitigate additional contractual and legal fees, utilize governments design team, and reduce implementation time from weeks to days.
- Further discussions related to the ongoing management of the costs associated with the upgrades are underway.

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**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division
May 26, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Supportive Recovery Homes

### TOPIC

- Supportive recovery homes are residences that offer time-limited supports and services (e.g., coaching for daily living, community reintegration, vocational and educational planning, lay counselling and case management, and group supports) to people in recovery from substance use disorders.
- Supportive recovery homes are regulated under the *Community Care and Assisted Living Act* (CCALA) and can be licensed or registered. Some homes also operate unlawfully, without licensing or registration, and may pose health and safety risks to the clients.
- In December 2019, amendments to the CCALA and new Assisted Living Regulation were brought into force to enhance the regulatory health and safety oversight for all assisted living residences.

### CURRENT SITUATION

- Concerns have been raised by stakeholders and media about safety and quality of care in supportive recovery homes.
- In December 2019, amendments to the CCALA and new Assisted Living Regulations were brought into force to enhance the regulatory health and safety oversight for all assisted living residences. The new regulations, while applicable to all classes, include specific requirements for supportive recovery services including ensuring employees have necessary training, skills and qualifications, personal service planning to support individuals in their recovery goals, and transition planning requirements to improve safety and connection for individuals leaving supportive recovery.
- New oversight powers also enable government to take immediate action if the health or safety of a resident is at immediate risk, by attaching conditions or suspending registrations.
- The Ministry of Health (MoH) and Ministry of Mental Health and Addictions (MMHA) have worked with partners to develop draft provincial standards for registered assisted living supportive recovery services. The draft standards focus on best/wise practices in the areas of health and safety, program/service delivery, and capacity building, and were created in collaboration with Indigenous partners, people with lived and living experience, operators, health authorities, and an expert advisory panel.
- MoH and MMHA are also working in partnership to develop supports for operators to understand and implement the standards in their services. Planned supports include webinars, tools/templates, and online training.
- A resource for individuals and families is also being developed to support individuals and their loved ones in understanding and navigating supportive recovery services in BC.

### KEY FACTS

- Supportive recovery homes offer hospitality, psychosocial supports, and other personal assistance services to provide individuals with the opportunity and support to focus on their recovery journey.
- In 2016, government amended the CCALA to increase the regulatory authority of the Assisted Living Registrar (ALR). The amendments were brought into force with new assisted living regulation on December 1, 2019, with enhanced regulatory powers and increased oversight to enforce new health and safety requirements for all assisted living residences.
- The new Assisted Living Regulation includes new requirements for supportive recovery including:
  - Ensuring employees have necessary training, skills and qualifications;
  - Providing program and policy information upfront to individuals and families so they can make informed choices about whether a service is right for them;
  - Developing a personal service plan for each resident to help them reach their recovery goals; and
  - Supporting individuals to safely transition and connect to ongoing services and supports in the community when leaving recovery homes.
- Under the CCALA, operators must register their supportive recovery homes through the MoH Assisted Living Registry if they (1) provide housing and support to more than two individuals, (2) offer one or more assisted living services such as psychosocial supports and/or medication management, and (3) provide hospitality services (i.e. meals, housekeeping, laundry, recreational opportunities, and 24-hour emergency response).

- Licensed services provide a higher level of care compared to registered assisted living services, and have enhanced requirements and oversight through health authority licensing.
- Registered residences are listed by community on the MoH website, which includes information on substantiated complaints.
- The ALR or delegate can inspect a residence if there is reason to believe an unregistered operator is offering the level of service which requires registration. Fines can be recommended if an operator does not comply with registration requirements.
- Confirmed unregistered and unlawful operators are also listed on the MoH website for 5 years.
- The ALR or delegate can also inspect a registered residence to ensure compliance with the CCALA and its regulations, which promotes and protects the health and safety of the clients.
- As of April 15, 2021, there are 118 registered supportive recovery homes across the province. Currently, supportive recovery homes are disproportionately located in the Fraser Health Authority, with 48 residences in Surrey alone[1].
- Concerns have been raised by stakeholders and media about the safety and quality of care in supportive recovery homes, including inconsistent application of evidence-based approaches leading to elevated risk to residents and wide variation in staff qualifications and quality and level of service provided. The new regulations address these concerns, including a new requirement of 20 hours of training for each staff member in the areas of counselling, psychosocial rehabilitation, trauma-informed care, and conflict resolution.
- Health authorities charge user fees (in alignment with the Ministry of Social Development and Poverty Reduction per diems) for clients in registered and licensed Mental Health and Substance Use facilities. User fees cover the cost of room and board, and do not include transportation costs, toiletries or other personal effects. Individuals not in receipt of income assistance are responsible for this fee, or can apply for a hardship waiver from the health authority.
- In February, 2021, the Province announced the creation of more than 100 new publicly funded treatment and recovery beds in 14 organizations across the Province[2]. Grants for these beds are being administered through the Canadian Mental Health Association in consultation with the Province and health authorities.
- As part of Budget 2021, the Province announced that 195 new substance use treatment and recovery beds would be created throughout the province to help more people get on a path to recovery.

## FINANCIAL IMPLICATIONS

- Registered recovery homes receive a daily per diem of $35.90, which increased from $30.90, and licensed servicers receive a daily per diem of $45.00, which increased from $40.00 on October 1, 2019, from the Ministry of Social Development and Poverty Reduction in lieu of support and shelter payments, for each resident who receives Income or Disability Assistance benefits.
- Training bursaries of up to $8,000 per residence are available through the Community Action Initiative to assist operators in reaching the goal of training compliance. Due to COVID-19, the call for training grants was extended, as many eligible courses were cancelled or postponed. As of February 2020, $94,500 in grants have been issued to 45 supportive recovery homes, with the deadline to apply extended to April 30, 2021.
- In response to financial hardship as a result of COVID-19, the Province awarded approximately $2 million in Treatment and Recovery COVID-19 Support Grants. 53 licensed or registered supportive recovery organizations applied and were granted funding from MMHA ranging from $25,000 to $45,000.
- In July 2020, the province announced an investment of $13.5 million over three years for new publicly funded treatment and recovery beds for adults throughout the province. The grants are being administered by the Canadian Mental Health Association-BC (CMHA-BC).

**Approved:**
April 26, 2021 – Teri Collins, ADM, Health Services Division
April 29, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] Updated data confirmed by ALR by email on April 15, 2021
[2] https://news.gov.bc.ca/releases/2021MMHA0004-000226

# LEGISLATIVE SESSION - FACT SHEET

## Surgical Renewal Plan 2020

### TOPIC

- On March 16, 2020, due to the COVID-19 pandemic, the decision was made to postpone non-urgent scheduled surgeries and only perform emergency and urgent surgeries to ensure hospital capacity was maintained throughout BC for potential COVID-19 patients.
- On May 7, 2020, the Commitment to Surgical Renewal was announced[1]. The plan aims to increase surgical capacity to address postponed surgeries that resulted from the first wave of COVID-19 and to meet the growing demand for surgery within the province. In a July 30 update on the plan, a timeline of 15-22 months for recovery of all postponed cases was proposed[2].
- On May 18, 2020, non-urgent scheduled surgeries resumed across all health authorities.

### CURRENT SITUATION

- On October 19, 2020, Wave 2 of the COVID-19 pandemic was officially announced in BC, and on April 12, 2021, Wave 3 was officially announced in BC. Both of these waves of COVID-19 have impacted surgical renewal efforts.
- Once the impacts of second and third-wave outbreaks are fully understood across the health authorities, the Ministry will re-examine the initial projected catch-up dates and make any revisions required to ensure those timelines remain accurate.

### BACKGROUND

- There are 5 key steps that the Commitment to Surgical Renewal outlines: 1) increasing surgeries; 2) increasing essential personnel; 3) focusing on patients; 4) adding more resources; and 5) reporting on progress.
- The Commitment to Surgical Renewal 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.
- Key components of renewal are being tracked and reported publicly on a period basis:
  - Focusing on Patients, where progress is expected in 4 areas: making calls to patients, prioritizing and completing postponed surgeries, performing urgent scheduled surgeries, and completing non-urgent scheduled surgeries;
  - Increasing Surgeries, where progress is expected in 4 areas: extending operating room hours, expanding summer capacity, improving operating room efficiency, and performing more surgeries; and
  - Increasing Essential Personnel, through progress in training and recruitment.
- In Progress Report #3: July-August 2020, it was reported health authorities planned to add 16% more surgical capacity (operating room hours) from June 15, 2020 to March 3, 2021 annualizing to a 24% in 2021/22.[3] Based on those plans, all health authorities were projected to catch-up to postponed surgeries by the end of 2021.[3]
- Impacts from the second and now third wave of COVID-19 in BC have impacted the above plans. The Ministry 2021/22-2023/24 Service Plan reflects this in the target 666,500 operating room hours.
- Health authorities estimate the hours added will reflect a 20% increase over the baseline, however at time of writing, BC is still experiencing impacts from the third wave and this increase may be further impacted.
- Eleven public progress reports have been released covering the period from May 18 to March 31, 2021.[4]

### KEY FACTS

- Health authorities have safely resumed surgeries. All health authorities were ramped up to pre-COVID-19 levels of activity by mid-June 2020.

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[1] BC Gov News. (May 7, 2020). Province Launches Renewal Plan for Surgeries. Retrieved from: https://news.gov.bc.ca/releases/2020HLTH0026-000830

[2] ProvinceofBC. (July 30, 2020). COVID-19 BC Update, July 30 [Video]. YouTube. https://www.youtube.com/watch?v=e4uSY-tKMqM&list=PLbER4Sxdn0R7Sef9_eWi-RNOnsZ0IP_6c&index=111

[3] BC Gov News. (September 17, 2020). Joint statement on B.C.'s COVID-19 response, latest updates. Retrieved from: https://news.gov.bc.ca/files/SurgicalRenewalReport3.pdf https://news.gov.bc.ca/files/SurgicalRenewalReport3.pdf https://news.gov.bc.ca/files/SurgicalRenewalReport3.pdf https://news.gov.bc.ca/files/SurgicalRenewalReport3.pdf

[4] BC Gov News. (May 27, 2021). A commitment to surgical renewal in B.C. - progress report #11: March 2021. Retrieved from: https://news.gov.bc.ca/files/surgical-renewal-progress-report-March-2021.pdf

- During the initial COVID-19 response surgeries were taking approximately 26% longer to complete due to a necessary increase in infection prevention controls.[7] By the June 26-July 23, 2020 reporting period, surgical efficiency returned to approximately pre-COVID-19 levels.
- On November 22, 2020, all health authorities completed their calls to 111,584 patients who were on waitlists before May 7 to ask them if they were ready to reschedule their surgery. A total of 8,049 entries from the waitlist were removed as people no longer required surgery or the health authority found data errors.[8]
- Between June 26, 2020 and March 31, 2021:
  - 264,043 surgeries were completed, including 97% of the cases in patients who had a surgery postponed in the first wave of COVID-19.[9] As patients are contacted for surgery, some patients, in consultation with their surgeon, have decided to no longer pursue a surgical intervention. As of this reporting period, 2,198 patients no longer wish to pursue surgery as a treatment, leaving 15,154 surgeries to be completed. As of March 31, 2021, health authorities have completed 97% of these surgeries.[4]
  - An additional 21,966 hours of operating room time were added compared to the same timeframe last year.[9]
  - 4,294 more urgent scheduled surgeries and 7,364 more surgeries for patients waiting longer than two times their target wait were performed.[9]
  - 8,547 more total surgeries performed compared to the same timeframe last year, including 9,208 more scheduled surgeries and 661 less unscheduled surgeries.[9]
  - Waitlists have been reduced. The total waitlist has been reduced by 13% compared to the same timeframe last year and 18% since it peaked on May 28, 2020. The urgent and non-urgent waitlist sizes have both decreased by 13%.[4]
- Since April 1, 2020, a total of 1,459 medical staff have been hired. That equates to 55 surgeons, 64 anesthesiologists, 4 general-practice anesthetists, 519 perioperative registered nurses, 74 perioperative licensed practical nurses, 308 post-anesthetic recovery registered nurses and 435 medical device reprocessing technicians.[4]
- Since April 1, 2020, 391 surgical specialty nurses have started their training and 274 have completed their programs.[4]

## FINANCIAL IMPLICATIONS

- On May 7, 2020, the Government announced it was allocating $250M to support the Surgical Renewal Plan 2020.[5]
- On September 9, 2020, the Government announced the Ministry of Health received approval to access operating funding of up to $1.616B and capital funding of $150M in 2020/21 to respond to the health-care requirements related to the COVID-19 pandemic response.[6] Of this amount, approximately $187M was allocated to support enhanced surgical capacity, including additional nursing staff and operating room costs.
- Budget 2021 provides $495M over 3 years to continue to support the surgical and diagnostic imaging strategy activities.

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**Approved:**
February 24, 2021 – Darlene Therrien obo Ian Rongve, ADM, COVID Response and Health Emergency Management Division
May 17, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
May 26, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 2, 2021 – Teri Collins, ADM, Health Services Division

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[5] Vancouver Sun (May 8, 2020). COVID-19: B.C. unveils plan to tackle surgeries postponed by pandemic. Retrieved from: https://vancouversun.com/news/covid-19-b-c-government-announces-250-million-plan-to-reopen-surgeries
[6] 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
[7] BC Gov News. (March 19, 2021) A Commitment to Surgical Renewal in B.C.- Progress Report #7: November – December 2020. Retrieved from: https://news.gov.bc.ca/files/surgical-renewal-commitment-progress-report7-Nov-Dec2020.pdfhttps://news.gov.bc.ca/files/surgical-renewal-commitment-progress-report7-Nov-Dec2020.pdfhttps://news.gov.bc.ca/files/surgical-renewal-commitment-progress-report7-Nov-Dec2020.pdfhttps://news.gov.bc.ca/files/surgical-renewal-commitment-progress-report7-Nov-Dec2020.pdf
[8] BC Gov News. (January 6, 2021) A Commitment to Surgical Renewal in B.C. – Progress Report #6: October – November 2020. Retrieved from: https://news.gov.bc.ca/files/SurgicalRenewalReport6.pdf
[9] AnalysisWorks data cumulative from June 26, 2020-March 31, 2021

# LEGISLATIVE SESSION - FACT SHEET

# Surgical Strategy (2017/18-2019/20) and 2020/21 Surgical Renewal Comparison

## TOPIC

Under the BC Surgical & Diagnostic Imaging Strategy[1] (announced March 2018), the goals were: 1) improve access to appropriate surgical services; and 2) improve the patient experience.

## CURRENT SITUATION

- On March 16, 2020, due to the COVID-19 pandemic, the Ministry of Health made the decision to postpone all non-urgent scheduled surgeries impacting the ability of the health authorities (HAs) to reach the volume and wait time targets of the above strategy by 2019/20 fiscal year end.
- The postponement of non-urgent surgeries until May 18, 2020 also significantly reduced the volume hip/knee and dental surgeries completed in 2020/21.
- On May 7, 2020, the Commitment to Surgical Renewal was announced[2] replacing the surgical component of the BC Surgical & Diagnostic Imaging Strategy. Surgical Renewal aims to increase surgical capacity to address postponed surgeries that resulted from the first wave of COVID-19 and to meet the growing and ongoing demand for surgeries within the province. This moves activities away from the target hip/knee replacement and dental priority areas.

## KEY FACTS

- In 2019/20, volume targets were wet for scheduled hip/knee replacement, dental and "all other" scheduled surgeries. The cumulative target across these three areas was 259,942 surgeries. This was an increase of 10,046 over 2018/19 actual volumes achieved (249,878).[3]
- In 2019/20 across 249,234 scheduled surgeries were completed across these three areas (10,690 below the 259,924[4] target).
- In 2019/20 health authorities collectively met the following target levels: **94.4%** hip and knee replacements, and **97.6%** dental surgeries (table 1).[3]
- In 2020/21 the previous surgical strategy was replaced by the Commitment to Surgical Renewal and as a result targets for hip and knee replacements and dental surgeries were not set in 2020/21.
- While no targets were set, these surgeries would have been prioritized under Surgical Renewal if they were cases that were postponed due to COVID-19 and/or were cases that had been waiting more than twice their assigned clinical benchmark wait times.
- It is important to note that under Surgical Renewal a shift in reporting for 2020/21 occurred to align cases completed reporting with the monitoring of operating hours, i.e., to capture full activity of operating rooms, no reporting exclusions. This differs from the Ministry's standard practice of reporting in which specific procedures are excluded when data holdings would present an incomplete picture of wait times. As this shift in reporting primarily impacts the "All Other" reporting category, this category is excluded from the tables below.

Table 1: Scheduled Surgery Targets and Actuals, 2016/17-2020/21[3]

| Procedure | 2016/17 Actuals | 2017/18 Actuals | 2018/19 Actuals | 2019/20 Actuals | % of 2019/20 Target Met | 2020/21 Actuals | % Change 2016/17 to 2019/20 | % Change 2016/17 to 2020/21 |
|---|---|---|---|---|---|---|---|---|
| **Hip/Knee Replacements** | 14,378 | 15,391 | 18,739 | 18,635 | 94.4% | 15,323 | 29.6% | 6.6% |
| **Dental** | 6,135 | 6,277 | 7,107 | 7,075 | 97.6% | 6,588 | 15.3% | 7.4% |

[1] Diagnostic Imaging Strategy announced March 2018: https://news.gov.bc.ca/releases/2018PREM0010-000460
[2] Retrieved September 22, 2020 from: https://news.gov.bc.ca/releases/2020HLTH0026-000830
[3] Community and Cross Sector Branch; Health Sector Information Analysis and Reporting Division, Ministry of Health (2020/21).
[4] Master Locked-in Numbers. These totals include scheduled surgeries, standard Ministry reporting exclusions applied. This differs from 2020/21 surgical renewal reporting in which all surgeries are reported.

# LEGISLATIVE SESSION - FACT SHEET

**Wait Times**

- From 2016/17 to 2019/20, the percent of patients waiting over 26 weeks decreased (improved) for hip and knee replacement surgeries and dental surgeries.
- Of note is in 2019/20 VCHA exceeded the wait time target of no more than 5% of patients waiting longer than 26 weeks for dental surgery. At P13 in VCHA, only 2.2% of dental surgeries were waiting longer than 26 weeks.[2]
- In 2020/21, despite COVID-19 and the postponement of non-urgent scheduled surgeries, from 2016/17 to 2020/21, the percent of patients waiting over 26 weeks decreased (improved) for hip and knee replacement surgeries and dental surgeries.
- Of note is in 2020/21 Northern Health exceeded the wait time target of no more than 5% of patients waiting longer than 26 weeks for dental surgeries. At P13, 4.2% of dental surgeries were waiting longer than 26 weeks.[3]

Table 2: Progress Made on Surgical Wait Times Percent Waiting Over 26 Weeks[3]

| Procedure | 2016/17 Actuals | 2017/18 Actuals | 2018/19 Actuals | 2019/20 Actuals | 2020/21 Actuals | 2016/17 to 2019/20 | 2016/17 to 2020/21 |
|---|---|---|---|---|---|---|---|
| | | | | | | PP Change | PP Change |
| **Hip and Knee Replacements** | 35.3% | 30.2% | 26.5% | 24.3% | 30.7% | -11.0 | -4.6 |
| **Dental** | 17.1% | 10.8% | 7.3% | 10.3% | 12.4% | -6.8 | -4.7 |

**Capacity**

- Work on increasing surgical capacity has been focused on extending operating room hours and gaining a true understanding of the potential operating room capacity. This work continues under the Commitment to Surgical Renewal.
- The total number of surgeries performed under contract with private surgical clinics in accordance with the *Canada Health Act* was 12,336 in 2019/20.[5]

**Integration and Coordination**

- Surgical Services Programs (SSPs) are first being implemented as Hip and Knee Replacement Programs (HKRPs). They are responsible for coordinating and/or providing the surgical services that a patient requires.
- 19 HKRPs have been established, with 11 achieving all eight attributes for a HKRP and 8 meeting at least the minimum attributes. Of these 8, health authorities are working to complete the final attributes. The COVID-19 pandemic resulted in some delays to previously planned work.

**Waitlist Management**

- A proof of concept for a provincial surgical waitlist management and scheduling system is being implemented. Vancouver Coastal, Fraser, and Interior health authorities are leading this work.
- Work is continuing, now in balance with the Commitment to Surgical Renewal,[6] to make sure patients are prioritized based on clinical need and scheduling is optimized with available resources.

**Patient Experience**

- Work is ongoing to notify patients of the key information they need as they wait, and ensure they have a point of contact to make enquiries about their status on the waitlist.Advice/Recommentations

Advice/Recommentations

**Support for Existing and New Staff**

- Success of the surgical strategy was in part dependent on having the necessary health human resources available to provide services, by way of interdisciplinary team-based care. This strategy is also a fundamental part of the Commitment to Surgical Renewal and will continue to be point of focus.
- In April 2018, the Ministry completed the Provincial Health Workforce Strategy 2018/19 – 2020/21.[7] It identifies 13 priority occupations and 4 priority service areas. These include anesthesia services, specialty nursing, physiotherapists, occupational therapists, sonographers and perfusionists.

[5] HSIAR, Community and Cross Sector Branch; PAS 3000.1125 – Private Contracts 2020-06.
[6] Surgical Renewal Plan 2020 https://www2.gov.bc.ca/assets/gov/health/conducting-health-research/surgical-renewal-plan.pdf
[7] Provincial Health Workforce Strategy https://hlth.sp.gov.bc.ca/sites/HLTH4/DMO/Facts/_layouts/15/DocIdRedir.aspx?ID=C565SY5XS6RD-588078954-44

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

- In 2018/19, the Ministry provided up to $100 million in targeted funding to support the Surgical and Diagnostic Imaging Strategy. In 2019/20, the Ministry increased the available funding up to $125 million. In 2020/21 the available funding has increased to $175 million.
- The Ministry has also received approval to access up to $1.6 billion in operating funding in 2020/21 to respond to the health-care requirements of COVID-19 and of this, $187 million has been committed for enhanced surgical capacity, including additional nursing staff and operating room costs.[8] The Ministry was also approved to reallocate up to $150 million in capital funding to support the COVID-19, and of this approximately $21.78 million is allocated to support the surgical strategy.

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**Approved:**

February 26, 2021 – Darlene Therrien obo Ian Rongve, ADM, COVID Response and Health Emergency Management Division
May 25, 202 - Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
June 1, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 9, 2021 – Kristy Anderson obo Teri Collins, ADM, Health Services Division

[8] https://news.gov.bc.ca/releases/2020PREM0050-001694

# LEGISLATIVE SESSION - FACT SHEET

## Tahltan Nation

### TOPIC

BC Emergency Health Services (BCEHS), Northern Health Authority (NHA) and the Ministry of Health worked with Tahltan Nation and the Stikine Primary Care Physicians group to develop an action plan aimed at decreasing wait times and improving access to care for patients in the Dease Lake area.

### CURRENT SITUATION

- Collaborative work continues with the Tahltan Nation on implementing changes and enhancements to better improve access to care in their community.
- Senior Executives from the Ministry, BCEHS, and Tahltan Nation meet monthly to discuss progress on the action plan. At most recent call, Tahltan representatives were happy with the progress to date, calling the project a "complete success".
- The following actions are continuing and on track:

**Aircraft Contracts**

- BCEHS established a contract with Summit Helicopters (Terrace) and one with Tundra Helicopters (Dease Lake, Atlin and Watson Lake, Yukon).
- Prince George Fixed Wing Aircraft will be increased to a 24/7 resource starting June 7, 2021, once critical care paramedic training is complete. The aircraft is currently being used as a day resource.

**Airport Improvements**

- The Ministry of Energy, Mines and Low Carbon Innovation is working with Tahltan Nation and mining partners to address some Dease Lake airport infrastructure improvements.
- In the interim, BCEHS dispatch has a process with the Ministry of Transportation operations in the north to adjust snow removal priorities if lifesaving airvac calls are required.

**Yukon**

The Ministry, BCEHS and NHA are working with the Yukon government to formalize an agreement for the acceptance of Dease Lake patients to Whitehorse General Hospital for treatment as required as one option for referral. This would include having Yukon Emergency Medical Services (air ambulance) transport patients to Whitehorse when appropriate.

- Practice is being put into place, when needed, ahead of the agreement being finalized.
- Discussions are underway between BCEHS and Yukon EMS to determine whether it is feasible and/or necessary for Yukon paramedics to be licensed through the Emergency Medical Assistants Licensing Board for point-to-point transfers. There are currently no barriers preventing Yukon paramedics from becoming licensed in BC.

### KEY FACTS

The following actions are complete:

**24/7 Escalation Process**

To reduce delays, every transfer from the Dease Lake area is now escalated to the director of Patient Transfer services for BCEHS and the Executive Lead, Emergency, Trauma and Transfer Services, NHA for complete in-the-moment situational awareness and direction.

**No-refusal Policy**

NHA put in place a no-refusal policy for all patient conditions being transported out of the Dease Lake area, which means that the receiving sites and physicians agree to automatic acceptance of these patients. This policy change allows BCEHS to begin transport planning earlier in the process to maximize daylight flying hours and reduce delays.

**BCEHS Dispatch Changes**

Ensures staff are reminded of the unique challenges of emergency transport out of Dease Lake and the new policies implemented (escalation and no-refusal).

Background

- In July 2020, Tahltan Nation raised concerns of inequitable access to health care for its members compared to the rest of BC in a letter to the Minister of Health and the MLA for Stikine. Prior to COVID-19, the average transfer time out of their territory was 17.5 hours and had risen to 20.5 hours since the onset of the pandemic.

# LEGISLATIVE SESSION - FACT SHEET

- In August 2020, Tahltan Nation met with the Premier, the Minister of Health and the MLA for Stikine to outline concerns around long wait times and a lack of collaboration from BCEHS and to propose solutions.

## FINANCIAL IMPLICATIONS

- Contracts are funded through the Provincial Health Services Authority/BCEHS.
- Two ad hoc contracts were awarded through a Request for Quote opened in 2017.
- The following contracts are active in support of the Tahltan region:

Government Financial Information

| Contract / Term | Company | Location, Service |
|---|---|---|
| Ad hoc - ongoing | Summit Helicopters | Terrace:<br>Ad hoc service, based in Terrace |
| Ad hoc - ongoing | Tundra Helicopters | Multiple:<br>Ad hoc service, based in Dease Lake, Watson Lake and Atlin |
| Direct Award - 36 months (November 01, 2020 to October 31, 2023) | North Cariboo Air | Prince George:<br>Day fixed wing, based in Prince George |
| Direct Award – 12 months (December 01, 2021 to November 30, 2021)<br><br>*New RFP posted on BCBid May 7th , 2021 to award a new contract for a 16 month term spanning December 1, 2021 to March 31, 2023) | Summit Helicopters | Prince George:<br>Day rotary-wing, based in Prince George |
| Direct Award – 36 months (November 01, 2020 to October 31, 2023) | Northern Thunderbird Air | Prince George:<br>Night fixed-Wing, based in Prince George<br>*Operating as day resource until mid-June 2021 |

**Approved:**
May 7, 2021 – Teri Collins, ADM, Health Services Division
May 12, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Wandering and Silver Alert

### TOPIC

Wandering is a common issue amongst those with dementia and is a serious safety concern.

### CURRENT SITUATION

- The Minister's Mandate Letter (2020) includes the following commitment:
  *With support from the Minister of Public Safety and Solicitor General, lead work with community groups and the B.C. Seniors Advocate to develop a made-in-B.C. "silver alert" system to help assist first responders in locating missing seniors, particularly those with dementia and Alzheimer's disease.*
- Individuals with cognitive impairment living in the community are at risk of harm if they wander. As such, a provincial system that engages the public in supporting these individuals to return home would be of great value in BC.
- There are various options for provincial silver alert system. A silver alert can function much like an Amber Alert, where law enforcement agencies and various partners increase collaboration to safely recover missing persons that meet strict criteria such as age or cognitive impairment. The public is also notified via radio, television, highway signs, and/or opt-in SMS messages, or other means.
- A citizen-led society called BC Silver Alert, is currently supported by donations, and provides subscriber-based public alerting in the lower mainland by:
  - scanning local police websites for news about missing persons,
  - assessing that information against Silver Alert Criteria; and
  - alerting subscribers via various alerting channels (email, Facebook, twitter).
- The Ministry of Health will examine different types of alert programs and technology, in partnership with key stakeholders, to recommend a made-in-BC province-wide system.
- The Ministry will commence work on a made-in-BC silver alert system in Fall 2021. Initial work will include conducting a jurisdictional review and developing a detailed stakeholder engagement plan.
- Both Emergency Management BC and the Ministry of Public Safety and Solicitor General have experience in alerting systems and will offer expertise on this important project.
- Cultural preferences and safety will be taken into consideration in the development of the silver alert system.

### KEY FACTS

- The Ministry has monitored the development of silver alert type systems across Canada, and will prioritize this work in Fall 2021, as the COVID-19 response becomes less demanding.
- February 2014, MLA Selina Robinson (Coquitlam-Maillardville) introduced *Bill M20- Silver Alert Act 2014* to create a silver alert system in BC, however, the Bill was not passed.
- February 2014, the Ministry of Justice proposed The *Missing Person's Act*,[1] which was given assent in March 2014, and has a similar goal of safe, swift recovery of missing adults. The Act outlines criteria under which a missing individual's information may be accessed. The Act does not outline what information is permissible to provide to the media.
- In 2014, a citizen-led initiative called the BC Silver Alert program was launched in Vancouver by the family of Mr. Shin Noh, an individual whose disappearance in September 2013 was the impetus behind Bill M20.[2] Mr. Noh was never found. This program employs social media to share information provided by family and friends of the missing individual. Volunteers then contribute their time to search on an ad-hoc basis.
- Following 2014, the Ministry worked collaboratively with the Ministry of Justice and consulted with Ontario, the Alzheimer Society of BC and the Missing Persons Centre (RCMP) on the issue of wandering. At that time, it was determined proactive steps to prevent wandering (including education for families) would be more appropriate than a provincial "Amber Alert" type system. Ontario also decided against a silver

[1] https://www.bclaws.ca/civix/document/id/complete/statreg/14002_01
[2] Story https://bcsilveralert.ca/Story/

alert type of program and introduced the "Finding Your Way" program, which is a safety awareness initiative for people with dementia that wander.

- The Alzheimer Society of BC website hosts a wandering kit similar to Ontario's "Finding Your Way" program which includes:
  - Information about wandering and strategies to reduce the risk of wandering.
  - An identification kit to record information helpful to police in the case of a wandering incident.
  - Information about MedicAlert® Safely Home® - Wandering Registry. This program provides seniors who wander with identification (medic alert bracelet), which allows police and other responders to quickly identify the person who has wandered and reunite them with their family. Information on potential wanderers submitted by a caregiver is stored on a secure database that is available to RCMP anywhere in Canada.
  - The Society also provides information directed to first responders about how to recognize, communicate, respond, and search for someone living with dementia.
- In late 2017, Alberta and Manitoba passed legislation that enables law enforcement organizations to work with the media to issue silver alerts. Alberta's *Missing Persons (Silver Alert) Amendment Act, 2017*[3] and Manitoba's *The Missing Persons Amendment Act (Silver Alert)*[4] focus on cases in which a vulnerable or at-risk person has not been seen by, or in contact with, the people who are normally involved in their lives. Both laws weigh safety requirements against privacy rights, requiring police to obtain a court order to issue a silver alert in all but emergency circumstances when time is critical.
- On May 31, 2018, a motion by Senator Pamela Wallin encouraging the federal government to institute a national silver alert was unanimously adopted in the Senate.[5]

## FINANCIAL IMPLICATIONS

- The Ministry and the Provincial Health Services Authority have provided up to $32.6 million to the Alzheimer Society of BC to support its First Link® and other programs for individuals and families affected by Alzheimer's disease and dementia. Government Financial Information
- Future costing specific to Silver Alert will be dependent upon the selected model/approach.

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**Approved:**
April 28, 2021 – Teri Collins, ADM, Health Services Division
May 5, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[3] Missing Persons (Silver Alert) Amendment Act, 2017
http://www.qp.alberta.ca/documents/Acts/2017ch23_unpr.pdf
[4] The Missing Persons Amendment Act (Silver Alert)
https://web2.gov.mb.ca/bills/41-2/b214e.php
[5] Motion to Encourage the Government to Institute a National Silver Alert Strategy
https://sencanada.ca/en/content/sen/chamber/421/debates/212db_2018-05-31-e#90

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# LEGISLATIVE SESSION - FACT SHEET

## Acute and Tertiary Care Mental Health and Substance Use Beds & Rooms

### TOPIC

- In BC, the with mental health and substance use (MHSU) conditions may access an array of health services within the hospital and community care framework including, but not limited to:
  - Mental Health Treatment/Intervention
  - Mental Health Housing with Supports
  - Acute and Tertiary care
  - Substance Use Treatment/Intervention
  - Substance Use Housing with Supports
  - Emergency Department admittions
- The severity, intensity, and the community/geography of a given MHSU case will determine the type of services available for a client. The Ministry of Health (MoH) collects data on publicly funded acute and tertiary psychiatric beds and rooms, emergency department rooms, and MHSU community services along with the average length of stay in acute care facilities.

### CURRENT SITUATION

Acute Care Beds & Rooms

- Health authorities provide acute care inpatient treatment to adults and youth experiencing mental illness, concurrent MHSU problems, and the acute stages of withdrawal from alcohol or other drugs. These specialized MHSU hospital inpatient beds and rooms are usually short-term in nature, providing assessment, treatment and stabilization; and are in facilities designated under the *Mental Health Act*.
- MHSU acute beds and rooms may be available under the following six facility-types categories: inpatient treatment (adult, youth, and geriatric); designated observation units; psychiatric intensive care units; short-term assessment; hospital-based withdrawal management (detox for adult or youth); and acute behavioural stabilization units.
- Acute care can also be provided in secure rooms, observation rooms, and quiet rooms. Observation rooms are only available in designated facilities/hospitals under *Schedule C*[1] of the Act. These hospitals may accept involuntary patients for short periods (up to 5 days) for assessment, treatment and stabilization, and further discharge to a nearby designated mental health facility for final treatment.

Tertiary Care Beds & Rooms

- Tertiary care beds and rooms meet the needs of individuals who require more intensive, long-term and/or specialized treatment, and have not been successfully treated in the primary and secondary mental health system. Services include assessment, treatment including stabilization of acute symptoms not resolved in other settings, and rehabilitation focusing on psychosocial rehabilitation and recovery.
- MHSU tertiary beds and rooms include in-patient (acute, rehabilitative, geriatric), residential care, eating disorder, neuropsychiatry, mood disorders, addictions/concurrent, and refractory psychosis services. In the *MHSU Semi-annual Bed Survey*, two types of rooms: secure room and quiet rooms are reported for tertiary care.
- Forensic psychiatric hospital beds are located at a secure, inpatient facility that provides court-related forensic psychiatric assessment, treatment, and community case management to adults experiencing MHSU problems who are in conflict with the law[2]. Specialized forensic mental health teams work to enable the re-integration of individuals back into the community.

### KEY FACTS

- Health authorities provide acute and tertiary level services for patients with serious MHSU disorders. People experiencing acute or longer term serious mental illness and/or substance-use disorders may require access to stabilization and supportive recovery (longer-term) services.

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[1] Designation under the Mental Heath Act [s3(1), (2)]. Retrieved from https://www.health.gov.bc.ca/library/publications/year/2016/facilities-designated-mental-health-act.pdf on February 9, 2021

[2] BC Mental Health and Substance Use Services. (2018). *Forensic Psychiatric Hospital.* Retrieved from http://www.bcmhsus.ca/our-services/forensic-psychiatric-services/forensic-psychiatric-hospital on March 1, 2018.

- In BC, as shown in Table 1, there are 818 acute care beds, 91 secure rooms, 13 observation rooms, and 8 quiet rooms. Fraser Health Authority (FHA) and Vancouver Coastal Health Authority (VCHA) report the the highest number of acute beds. However, FHA and VCHA reported no observation or quiet rooms.
- Acute Behavioural Stabilization Unit (ABSU) service is only provided at VCHA's St. Paul's Hospital, with 5 beds and 4 secure rooms. Adult or Youth Withdrawal Management (detox) - Hospital-Based service is provided at VIHA's Victoria General Hospital with 4 beds.[3]
- In 2019/20, acute care patients with a mental health diagnosis, under the Act, had an average length of stay (ALOS) of 13 days[4].
- In August 2020, FHA opened a new unit at Royal Columbian Hospital with 20 acute beds. Additionally, 25 beds were added due to the move of the Integrated Practice Units (IPU) facility to a new building.[5]

**Table 1: Mental health and substance use acute beds & rooms in BC, September 30, 2020[6]**

| Health Authority | Beds | Secure Rooms | Observation Rooms | Quiet Rooms |
|---|---|---|---|---|
| IHA | 104 | 13 | 3 | 5 |
| FHA | 266 | 22 | | |
| VCHA | 228 | 29 | | |
| VIHA | 161 | 21 | 3 | 2 |
| NHA | 59 | 6 | 7 | 1 |
| PHSA | | | | |
| **BC Total** | **818** | **91** | **13** | **8** |

- Table 2 shows that there were 1,279 tertiary MHSU beds in BC, of these beds, 606 beds were dedicated to in-patient (acute, rehabilitative, and geriatric) treatment[7]. Provincial Health Service Authority (PHSA) reported the highest number of tertiary beds (354), and followed by FHA (269) and VCHA (245).
- A total of 60 secure rooms were reported for tertiary care. The secure rooms are in designated mental health facilities and provide client seclusion . There were 9 tertiary quiet rooms, providing non-stimulating quiet environment for persons with complex behaviors not requiring a secure room.
- In BC, Tertiary Eating Disorder Service is available in Vancouver and administered by PHSA and VCHA with 14 and 7 available beds, respectively. Tertiary Refractory Psychosis Service, reported by VCHA, is available in Vancover, providing 25 beds and 2 secure rooms.[8] Forensic Psychiatric Hospital in Coquitlam, reported by PHSA, is the only forensic psychiatric hospital in BC, providing 190 beds and 20 secure rooms as of September 2020 Bed Survey. [9]
- Children and youth had access to 34 dedicated Tertiary Child and Youth Services beds, 9 secure rooms and 1 quiet room. Of these 34 beds, 26 were located in BC Children's Hospital, and the other 8 beds were in Kelowna General Hospital.[10]
- In September 2020, the 30 beds at Heartwood Centre for Women located at BC Women's Hospital, previously reported as community beds, are now reported as Tertiary Substance Use/Concurrent services. In April 2020, a new facility (Peace Arch Hospital Foundation Lodge) opened under Fraser Health Authority, adding 73 tertiary beds and replacing two contract facilities (Arbutus Place and The Residences at Clayton Heights).[11]

[3] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx
[4] HSIAR Division. Ministry of Health. (2021). *2021-02-05 Mental Health Hospitalizations in BC 2008/09-2018/19.* Project 3000_0220.
[5] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx
[6] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx Reported data is based on submitting HA, and not on physical location.
[7] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx
[8] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx
[9] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx
[10] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx
[11] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx

**Table 2: Mental health and substance use tertiary beds & rooms in BC, September 30, 2020[12]**

| Health Authority | Beds | Secure Rooms | Quiet Rooms |
|---|---|---|---|
| IHA | 164 | 5 | |
| FHA | 269 | 9 | |
| VCHA | 245 | 9 | 5 |
| VIHA | 178 | 8 | 3 |
| NHA | 69 | | |
| PHSA | 354 | 29 | 1 |
| **BC Total** | **1,279** | **60** | **9** |

## FINANCIAL IMPLICATIONS

The MHSU sector operating expenditures for 2019/20 were approximately $1.78 billion.

**Approved:**

April 27, 2021- Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
April 28, 2021 - Martin Wright, ADM, Health Sector Information Analysis & Reporting Division

[12] HSIAR Division. Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx

# LEGISLATIVE SESSION - FACT SHEET

## Attachment to a Primary Care Provider

### TOPIC

- "Attachment" describes an ongoing care relationship between a primary care provider (group practice or individual physician or nurse practitioner) and a patient. A patient is attached to a primary care provider for the life of the patient or career of the provider unless the patient moves away or changes to a different provider.
- The proportion of the BC population unattached to a primary care provider is an indicator of the need for primary care resources.

### 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, provincial level estimates only).

### KEY FACTS

Current/Historical Attachment Measures

- In support of patient attachment to primary care, the Health Connect Registry (HCR) will be 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. Once launched, Registration will be available online at HealthLinkBC.ca or by phone at 8-1-1 for those who require additional supports or translation. 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.

The Attachment Algorithm

- The algorithm is derived from Medical Services Plan (MSP) data on patterns of primary care use.
- 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.
- Once a patient is identified as attached to a group practice, the algorithm identifies whether the patient has had a majority of visits with a single provider within the practice; if so, the patient will be categorized as attached to that individual practitioner.
- Attachment to group/solo practice is the attachment measure most commonly used by the Ministry, because it better reflects the status 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. That patient is still receiving longitudinal primary care from the practice.

**Table 1: Patient Attachment Status for Last 5 Fiscal Years[1],**

| Fiscal Year | % Attached | Attached | Unattached | Unknown |
|---|---|---|---|---|
| 2019/20 | 75% | 3,932,257 | 813,098 | 512,643 |
| 2018/19 | 75% | 3,870,379 | 798,977 | 469,466 |
| 2017/18 | 76% | 3,822,628 | 776,850 | 438,715 |
| 2016/17 | 77% | 3,787,651 | 746,990 | 407,296 |
| 2015/16 | 77% | 3,740,680 | 728,931 | 390,400 |

[1] Ministry of Health, Health Sector Information, Analysis, & Reporting Division, Attachment Algorithm

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

- The CCHS provides a patient perspective on attachment that has 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.

**Measures Supporting PCN Implementation**

On-Going Monitoring of Attachment

- The algorithm may not pick-up changes in a patient's attachment status for a year or longer, as it requires a number of visits to capture a change in status.
- 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.

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 that needs to be attached in the community during their PCN service planning 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.
    - Working with the community also allows for development of a more accurate picture of primary care delivery; e.g. the community may indicate that an FTE practitioner devotes 0.4FTE to maternity care and is therefore only available to deliver general primary care for 0.6FTE.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

January 28, 2021 – Eric Larson, ED, Health Sector Information, Analysis & Reporting Division
February 24, 2021 – Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

# LEGISLATIVE SESSION - FACT SHEET

## BC Data Innovation Program

### TOPIC

Ministry of Health's contribution to the Data Innovation Program (DIP) formerly Data Integration Office (IDO) and BC Centre for Data Innovation

### CURRENT SITUATION

The Data Innovation Program is a data integration and analytics program for government supported by Population Data BC, an internationally recognized academic organization that has facilitated population-based research for over 20 years.

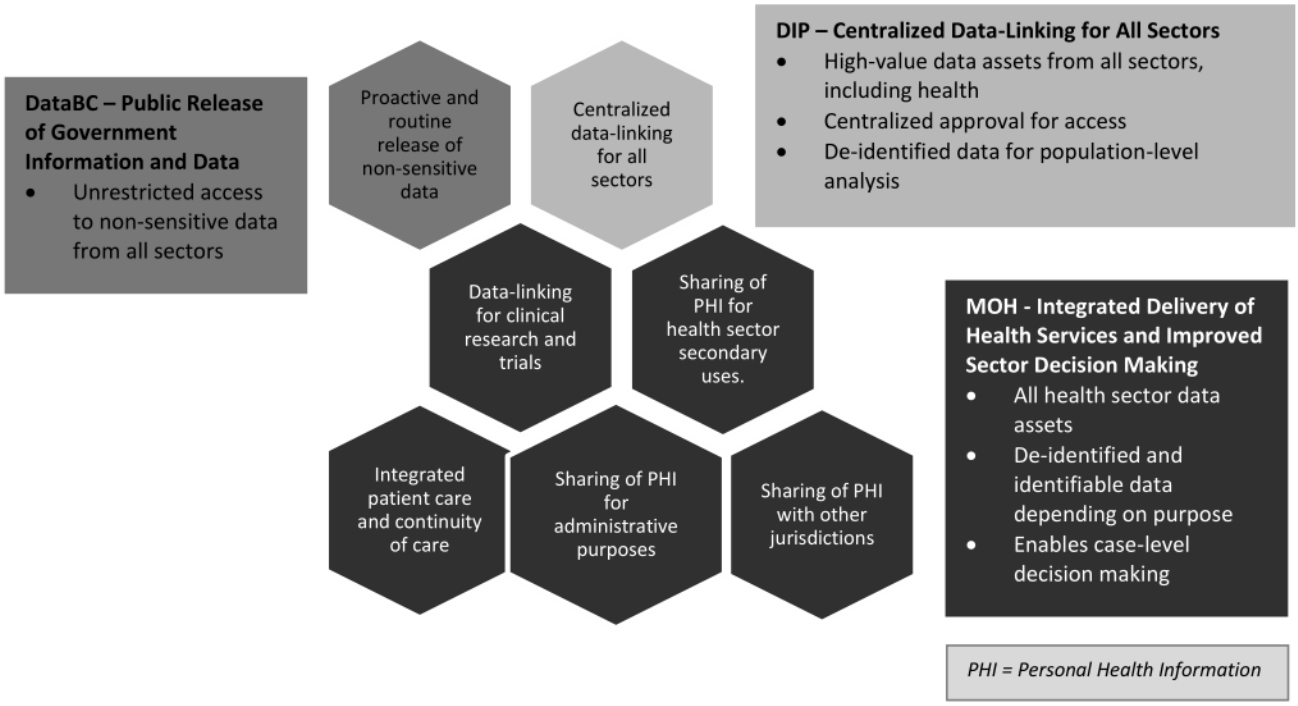
### KEY FACTS

- At the December 2013 Data Effect Conference, the Minister of Health announced the establishment of a Working Group to conduct a review and make recommendations on the creation of a BC Centre for Data Innovation (BCCDI).
- BCCDI is a vision for the future that will foster innovation and collaboration between citizens, researchers, the private sector and government. Based on leading practices in security and privacy, BCCDI will provide a secure environment for data-driven innovation, transformative research and technology development.
- A joint working group of the Ministry of Health and the Ministry of Technology, Innovation and Citizens' Services was established to evaluate the potential for such a centre and to make recommendations that initially focus on the health sector but are extensible to broader, cross-sector data needs.
- The working group's report[1] proposed a multi-year, incremental approach to developing BCCDI and recommended a set of first steps or foundational activities towards realizing that vision.
- The Ministry's foundational contribution is the Health Data Platform (HDP) work being led under the Strategy for Patient Oriented Research. The Canadian Institute for Health Research has approved BC's business plan for the Support for People and Patient Oriented Research and Trials Unit. This work is co-funded by the Ministry to support health sector priorities.
- The HDP will be a federated virtual data environment to enable data sharing across the health sector to support health system analysis and research.
- Key focus of the HDP is to:
    - Enable secure third party access to the Ministry's and health authorities' secondary use data holdings
    - Streamline cross organizational access request and approval processes in the health authorities and the Ministry.
    - Enable access to and analysis of patient experience data.
- The broad objective of the Ministry's work is to enable patient-oriented improvements to the fragmented health care system that supports sector case-level and population- level decision making. While the broad objective of Data Innovation Program's work is population-level analysis and enabling improved access to high value data from and across all sectors.
- Ministry of Citizen Services is the government lead for the Data Innovation Program.
- Ministry of Health is a key partner and meets regularly with the DIP team at the senior and working levels.
- Health and Data Innovation Program have a unified strategy to align the initiatives to improve access and use of public sector data.

[1] http://www.gov.bc.ca/citz/down/BC_Centre_for_Data_Innovation-FINAL.pdf

# LEGISLATIVE SESSION - FACT SHEET

The following diagram depicts the key differences between the 2 initiatives.




## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 4, 2021 - Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

# LEGISLATIVE SESSION - FACT SHEET

## Canadian Institute for Health Information – Your Health System

### TOPIC

The Canadian Institute for Health Information (CIHI) has an interactive website called 'Your Health System'[1] for the health sector and general public.

### CURRENT SITUATION

The 'Your Health System' website is updated twice a year; once during the Fall and once during the Spring. The most recent update was released on December 10, 2020 and includes data up to 2019-2020 for many indicators.

### KEY FACTS

- This web tool consists of three sections: 'In Brief', 'In Depth', and 'Insight'.
- 'In Brief' and 'In Depth' enable users to view comparable provincial/territorial, regional, and facility level performance based on a number of performance indicators, while 'Insight', is designed for health care providers and analysts (login required) to examine indicator results in greater detail.
- Data to support performance results is collected from various sources, including by CIHI directly from hospitals and long-term care facilities, by Statistics Canada from public surveys, and from other government sources[2].
- Each province has structured health care delivery differently, based on a variety of factors. Therefore, though most interprovincial performance comparisons on the CIHI website are valid, there are some instances where interpreting interprovincial results should be done with caution.[3]
- Generally, the historical information shows that British Columbians perform better than the Canadian average with respect to general health and well-being (for example, in the categories of 'Social Determinants' and 'Health Status'). British Columbians maintain lower rates of smoking, obesity, and a higher rate of physical activity during leisure time. Compared with the Canadian average, these indicators suggest long-term strengths which enable a healthy population.
- However, British Columbia children perform below the Canadian average on a key 'Social Determinant' indicator, 'Percent of Children Vulnerable in the Areas of Early Development'. This indicator is considered an important determinant of health and well-being in later life. In particular, the province scores almost nine percentage points higher (worse) than Ontario. This means that children across British Columbia have greater vulnerabilities in at least one area of child development when entering kindergarten (including physical health, emotional well-being, language, and social skills).
- Other performance indicators relating to mental health and wellness (in acute and community care) where the province's health facilities do not perform as well as the Canadian average include repeat hospital stays (three or more in a single year) for mental illness, the potentially inappropriate use of antipsychotics in long-term care, and the use of restraints in long-term care.
- Of the five performance indicators on the website which relate to readmissions to hospital, British Columbia performs below the Canadian average on three. While not all readmissions can be prevented, the rate can often be reduced through improved follow-up and coordination of care for patients after discharge.
- Overall, CIHI's assessment of the province's health system reinforces existing knowledge within the Ministry regarding the province's health care system, and initiatives have been taken that should result in improvements in several areas.

[1] http://yourhealthsystem.cihi.ca/

[2] For example, the Early Development Instrument is a kindergarten teacher-completed checklist.

[3] For example, there are differences among provinces in use of and reporting to CIHI by psychiatric hospitals, which can affect the mental health and/or substance use indicators.

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

January 26, 2021 - Heather Richards, Health Sector Information, Analysis and Reporting Division
February 4, 2021 – Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

# LEGISLATIVE SESSION - FACT SHEET

# Child and Youth Mental Health and Substance Use Beds

## TOPIC

A range of mental health and substance use (MHSU) community residential treatment, residential care, and supported housing options are available for children and youth with mental health and/or substance use problems, in order to respond appropriately to an individual's service needs.

## CURRENT SITUATION

- Mental illnesses develop mostly during adolescence and young adulthood[1]; research indicates that half of all cases of mental disorder begin by age 14, and three-quarters by age 24, while half of all people with a substance use disorder will have experienced substance use issues before the age of 20[2]. Therefore, treatment and early intervention have significant upstream effect on the overall mental health and problematic substance use in the population.
- 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.
- Beds generally should be reserved for children and youth who require a higher intensity of services and supports, to address complex or acute mental health or substance use problems.
- There is evidence community-based treatment is associated with substantially better outcomes than inpatient treatment and care, and shorter stays in hospital are as effective as longer stays (World Health Organization, 2003).
- Bed-based services for children and youth include services delivered through hospitals and short term, intensive programs such as withdrawal management, residential treatment, and supportive recovery services and longer term supported housing.
- Substance use beds are for youth with a primary substance use problem. Mental health beds are for youth with a primary mental health problem. However, each service has the capability to respond to the unique needs of the youth, which may include access to mental health or substance use care. Some mental health beds are dedicated to youth to treat a particular diagnosis, such as eating disorders.
- Health authorities are responsible for providing substance use services in a variety of community residential settings. Community substance use treatment and intervention services include:
    - Eating disorder services: Licensed community residential care facility.
    - Withdrawal management (detox): A hospital, community residential (non-hospital), or a supportive residential setting, where individuals going through the acute stages of withdrawal from substances are medically monitored or supervised.
    - Transitional services: A temporary residential, substance-free setting that provides a safe, supportive environment for individuals who are experiencing substance use problems and requiring short to medium-term supports.
    - Residential treatment: Time-limited, live-in intensive treatment for individuals who are experiencing substance use problems, and whose assessment indicates that they will be effectively served through intensive treatment.
    - Supportive recovery: A temporary residential, substance-free setting that provides a safe, supportive environment for individuals who are experiencing substance use problems and require time-limited supports.
    - Supported housing: Affordable and safe permanent housing, home support services, and MHSU clinical case management services.

[1] Government of Canada (2006). The human face of mental health and mental illness in Canada, page 34, retrieved from: https://www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf

[2] Kessler et al., (2005): doi:10.1001/archpsyc.62.6.593 .

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

According to the September 30, 2020 MHSU Bed Survey, of 20,353 mental health and substance use beds in the province 285 beds are child and youth mental health and substance use beds[3] :

- 59 child and youth community mental health beds,
- 124 child and youth community substance use beds[4], and
- 102 acute and tertiary beds for young people throughout the province. See Table 1 below:

**Table 1: MHSU Child and Youth Beds[5]**

| TYPE OF BED OR FACILITY | IHA | FHA | VCHA | VIHA | NHA | PHSA | BC TOTAL |
|---|---|---|---|---|---|---|---|
| Acute Care Inpatient Treatment Beds Youth/Adolescents | | 20 | | 14 | 6 | | **40** |
| Adult or Youth Withdrawal Management (detox) Hospital-Based | | | | 4 | | | **4** |
| **ACUTE** | | **20** | | **18** | **6** | | **44** |
| MH Community Assisted Living | | 6 | | | | | **6** |
| MH Community Residential Care | | 9 | | 6 | | 14 | **29** |
| MH Supported Housing Group Homes | | 24 | | | | | **24** |
| SU Supported Housing Youth | | | | 3 | | | **3** |
| SU Youth Residential Treatment | | 20 | 18 | | 7 | 22 | **67** |
| SU Youth Supportive Residential Services (Supportive Recovery) | | 4 | 11 | 8 | | | **23** |
| SU Youth Transitional Services | | | | 4 | | | **4** |
| SU Youth Withdrawal Management (detox) Facility Based | 4 | 6 | 5 | 9 | 1 | | **25** |
| SU Youth Withdrawal Management (detox) Supportive Residential | 1 | | | 1 | | | **2** |
| **COMMUNITY** | **5** | **69** | **34** | **31** | **8** | **36** | **183** |
| Tertiary Child and Youth Services | 8 | | | | | 26 | **34** |
| Tertiary Eating Disorder Services | | | | | | 14 | **14** |
| Tertiary Substance Use/Concurrent Services | | | 10 | | | | **10** |
| **TERTIARY** | **8** | | **10** | | | **40** | **58** |
| **HA AND BC TOTALS** | **13** | **89** | **44** | **49** | **14** | **76** | **285** |

- The above bed numbers exclude bed-based treatment services provided by the Ministry of Children and Family Development, such as youth forensic services, residential treatment services offered at the Maples adolescent treatment centre for young people with psychiatric and behavioural disorders, and alcohol and drug residential treatment services for youth involved with the criminal justice system.
- Government continues to invest in bed-based services for young people. As part of the response to the overdose public health emergency, in August 2020, a new facility, Traverse, opened within the Fraser Health Authority adding 20 beds for young people with problematic substance use as Youth Residential Treatment [6].

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
March 31, 2021 –Christine Voggenreiter, ED, Health Sector Information, Analysis & Reporting Division
April 8, 2021 - Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

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[3] Child and youth beds are for clients aged 30 years old and younger
[4] For clients 30 years old or younger. Additionally, 22 Adult Supportive Residential Services (Supportive Recovery) beds were reported by FHA for clients aged 19-24.
[5] Source: HSIAR Division, Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx For clients aged 30 years old and younger. Data is reported based on location of the submitting HA and not based on the physical location of HA.
[6] HSIAR Division, Ministry of Health. (2020). September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx

# LEGISLATIVE SESSION - FACT SHEET

## Community Mental Health and Substance Use Beds

### TOPIC

A range of mental health and substance use community residential treatment, residential care, and supported housing options are available for individuals with mental health and/or substance use (MHSU) conditions, in order to respond appropriately to an individual's health service needs.

### CURRENT SITUATION

Mental Health Community-based Care

Health authorities provide community mental health care through three main programs: Licensed community residential care facilities, family care homes, and community crisis stabilization beds. Community residential care facilities range in size from 5 to 65 beds[1] and are licensed under the Community Care and Assisted Living Act (CCALA) for individuals who cannot live independently. Family care homes, while unlicensed, also provide care for individuals who cannot live independently and require supports in a family setting. Family care homes accommodate up to two residents and must meet requirements set out by each health authority. Community crisis stabilization beds are a voluntary community-based alternative to inpatient crisis stabilization for patients benefitting from a community and more home-like setting.

Substance Use Intervention and Treatment Beds

Health authorities are responsible for providing substance use services in a variety of community and residential settings. Community substance use treatment and intervention services include:

- **Sobering and Assessment:** Short-term (less than 24 hours) facility for people under the influence of substances. Monitoring of health is provided as it relates to acute intoxication.
- **Adult and Youth Withdrawal Management (detox):** A hospital, community residential (non-hospital), or a supportive residential setting where individuals going through the acute stages of withdrawal from substances are medically monitored or supervised.
- **Adult and Youth Transitional Services:** A temporary residential, substance-free setting that provides a safe, supportive environment for individuals who are experiencing substance use problems and requiring short to medium-term supports.
- **Adult and Youth Residential Treatment:** Time-limited, residential programs for individuals who are experiencing substance use problems and whose assessment indicates that they will be effectively served through intensive treatment. Settings are usually licensed under the CCALA. Programs generally range from 30-90 days.
- **Adult and Youth Supportive Recovery:** A temporary residential, substance-free setting that provides a safe-supportive environment for individuals who are experiencing substance use problems and require time-limited supports. Supportive recovery beds meet the needs of individuals who are preparing to enter residential treatment, who have left more intensive residential treatment but require additional support to reintegrate into the community, or require a longer term structured environment while preparing to transition into a more stable lifestyle. (For more details see Government Commitment to 500 Additional Addiction Spaces fact sheet).

MHSU Supported Housing

Health authorities provide MHSU supported housing units for people with severe MHSU disorders; supported housing services are delivered through an array of configurations that include three core components: Affordable permanent housing units, home support services, and MHSU clinical case management services. Models include clustered supported housing, congregate care, wet housing for clients with severe substance use problems, and scattered supported housing such as the Supported Independent Living Program.

[1] HSIAR Division, Ministry of Health, (2020), September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx.

# LEGISLATIVE SESSION - FACT SHEET

BC Housing

BC Housing is responsible for providing access to safe, affordable and appropriate mainstream housing for people in greatest financial need, including subsidized housing for individuals with mental health and substance use problems.

## KEY FACTS

- A stable, supportive living environment is an important determinant of both physical and mental health and well being. People who are struggling with substance use or their mental health require a range of residential treatment, residential care, and supported housing options to support their recovery and to live effectively in their communities.
- Health authorities provide a wide range of community mental health and substance use programs for people with serious mental and/or substance use disorders. These include short term, intensive residential programs, such as withdrawal management and substance use residential treatment programs, and longer-term housing such as community residential care, family care homes, and supported housing.
- Through a partnership with BC Housing and health authorities, the BC Housing Health Services Program provides increased access to safe and affordable housing units, directly managed or funded through BC Housing, for individuals with mental health and/or substance use problems.
- As shown in Table 1, between September 2015 and September 2020 substance use beds have increased by approximately 13% and mental health beds have increased by approximately 27%.

**Table 1: Mental Health and Substance Use Community Residential Beds in BC by Region (September 2015 and September 2020)**

| Health Authority | Substance Use Beds | | Mental Health Beds | |
|---|---|---|---|---|
| | 2015[1] | 2020[2] | 2015[1] | 2020[2] |
| IHA | 151 | 222 | 1,073 | 1,684 |
| FHA | 366 | 477 | 3,083 | 3,911 |
| VCHA | 1,584 | 1,571 | 5,511 | 7,128 |
| VIHA | 476 | 590 | 1,689 | 1,873 |
| NHA | 90 | 121 | 474 | 448 |
| PHSA | 34 | 78 | 167 | 153 |
| **BC Total** | **2,701** | **3,059** | **11,997** | **15,197** |

*[1] HSIAR Division. Ministry of Health (2015). September 39, 2015. MHSU Bed Survey. 2015_0689 MHSU Bed Information 2015-09-30.xlsx.*
*[2] HSIAR Division, Ministry of Health, (2020), September 30, 2020 MHSU Bed Survey. 3000_0285 MHSU Bed Information 2020-09-30.xlsx.*

## FINANCIAL IMPLICATIONS

- In 2017/18, the Ministry of Health provided $10 million to the health authorities (including the Provincial Health Services Authority (PHSA)) for Specialized Residential Treatment Beds. In addition, the Ministry provided PHSA $2.15 million for Specialized Youth Treatment Beds. The total funding for these treatment beds is $12.15 million.
- The MHSU sector operating expenditures for 2019/20 were approximately $1.78 billion.

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**Approved:**
March 4, 2021– Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
March 9, 2021- Martin Wright, ADM, Health Sector Information, Analysis and Reporting

# LEGISLATIVE SESSION - FACT SHEET

# Health Data Platform

## TOPIC

Health Data Platform (HDP) will enable timely, safe access to linked health system data in support of cross organization research and analysis in a secure virtual data environment.

## CURRENT SITUATION

In July 2020, the Health Data Platform (HDP) launched a minimum viable product to support priority COVID-19 requests from the Ministry, health authorities and researchers in academia following a common cross organization data access request process. Starting in February, new technology and data sets will be released, and access will be opened to all eligible projects.

## KEY FACTS

- The HDP supports research and analysis both within the health sector and in academia, by allowing access to health data from multiple sources to be brought together as required (on-demand), linked, de-identified and analyzed on a single secure platform.
- HDP's goal is three-fold: provide more timely, secure and consistent access to integrated health data from organizations across the sector, establish an even sector privacy and security landscape, and increase process transparency and efficiency for data contributors and data consumers
- HDP is being developed and led by the MoH with matched funding from the Canadian Institutes of Health Research, Strategy for Patient-Oriented Research (SPOR), organizations contributing data are included in its governance. The BC SPOR SUPPORT Unit is under the governance of the Academic Health Science Network (AHSN) Society and will provide the research infrastructure for the AHSN.
- HDP will deliver the main data platform and data services as outlined in the Phase 1 BC SUPPORT Unit business case. The Phase 1, non-competitive grant, ends in 21/22. The Phase 2 business case, a 5-year grant starting 21/22, has been submitted to CIHR with a response expected in April 2020. The data platform and services continue to be a core component.
- PopData will continue to provide the front counter services for academic research requests and has now been expanded to include cross organizational research requests for the sector.
- Data Innovation Program (DIP) in Citizen Services is a complementary initiative also underway for Crown data which seeks to leverage public sector data to enable innovation, transform decision-making and enable informed citizens. Bilateral discussions continue to align efforts.
- The major projects under HDP include:

| | |
|---|---|
| **BC Data Scout™** | Launched in February 2018, BC Data Scout™ offers timely support to BC researchers to understand the quality and availability of Ministry data to conduct successful health research studies and secure third-party research funding. |
| **Streamlining Data Access** | Starting July 2020, cross organizational sector data access requests will follow a new streamlined application, approval and data assembly process which will promote consistency, enhance transparency, and provide timelier access to data. |
| **HDP Data Services** | Minimum viable product launched July 2020, services include mechanisms to assembles data safely from participating data contributors, to provision the assembled data in a secure environment for analysis, a secure environment for data analysis, data output control process, and supporting services and tools to facilitate responsible data use. Next release scheduled for January 2020. |
| **Healthideas** (MoH Data Warehouse) | A variety of projects completed to enable secure third-party access, related security enhancements, data acquisitions and linkage. Work is completed. |
| **Population Data BC Direct Access Project** | Popdata's direct access to Healthideas is to facilitate contemporaneous access to data for researchers. Work is ongoing. |
| **Patient Centred Measurement Data** | Provincial data resource of self-reported experience and satisfaction of patients in a range of health care sectors surveys made available in Healthideas. |

- The launch in July started with a COVID data library to support high priority research and analysis to inform pandemic management. Efforts are underway with Ministry and PHSA to continue to grow the data available to HDP and efforts will begin in 21/22 to make data available from the regional health authorities. As of February 2020, the following are available:

| Data Set | Description |
|---|---|
| COVID test lab data | COVID 19 tests performed and the test result |
| Case data | Cases as identified by public health |
| Hospital Admissions | • COVID and non-COVID patients in ICU<br>• COVID patients in non-ICU |
| Mortality data, Vital Statistics | All deaths |
| Fee for Service (MSP) data | • Claims information<br>• Coverage eligibility<br>• Insured services information |
| Chronic Disease Registry | • Chronic disease incidence<br>• Chronic disease prevalence |
| Discharge Abstract Data (DAD) | • Inpatient<br>• Day surgery |
| National Ambulatory Care Reporting System (NACRS) | Emergency department visits |
| Health System Matrix | • Population segments<br>• Person-level healthcare utilization<br>• Estimated healthcare costs<br>• Utilization by Service Line |
| Pharmanet | • Prescription information<br>• Claims regardless of who pays for the prescription |
| Client Roster | Client information by calendar and fiscal year |
| 811 | Calls to 811 for respiratory conditions |
| Cardiac Services British Columbia (CSBC) | Basic information on patients in BC who received interventional cardiology, cardiac surgery or attended an A Fib Clinic |
| Transfusion Registry | Subset of the transfusion registry dataset including whole blood, plasma and platelet recipients |

## FINANCIAL IMPLICATIONS

The total funding for the Health Data Platform is outlined below:

- The Ministry has committed $8.9M over a 5-year period (ending fiscal 2020/21) to support BC's SPOR and Trials (SUPPORT) Unit. The Canadian Institute for Health Research has approved matching funds of $8.9M. Work is underway to extend this agreement.

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**Approved:**
February 4, 2021 – Martin Wright, ADM, Health Sector Information, Analysis & Planning & Reporting Division
February 25, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## 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 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 two years starting July 1, 2013. At the completion of the two years, the Ministry and the five regional health authorities (HAs) committed to ongoing monitoring.

### 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 four Ministry-authorized, standardized TRR forms, each applicable for 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. 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. Health authorities 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.

### KEY FACTS

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

| 2014/15 | | | | 2015/16 | | | | 2016/17 | | | | 2017/18 | | | | 2018/19 | | | | 2019/20 | | | | 2020/2021 | | | Total Cumulative |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | |
| 564 | 493 | 544 | 707 | 569 | 498 | 521 | 721 | 632 | 583 | 615 | 771 | 655 | 549 | 599 | 740 | 772 | 632 | 835 | 885 | 802 | 632 | 737 | 745 | 592 | 574 | 670 | 17,637 |
| subtotal=2,308 | | | | subtotal=2,309 | | | | subtotal=2,601 | | | | subtotal=2,543 | | | | subtotal=3,124 | | | | subtotal=2,916 | | | | subtotal=1,836 | | | |

- The number of TRR approvals over the period April 1, 2014 to December 31, 2020, per HA[4]:

| Total Number of TRR approvals by health authority | Interior | Fraser | Vancouver Coastal | Island | Northern | Total Cumulative |
|---|---|---|---|---|---|---|
| | 8,905 | 1,860 | 2,052 | 3,900 | 920 | 17,637 |

- 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 April 1, 2014 to December 31, 2020, there was a cumulative

[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.
[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 Q - Temporary Rate Reduction Report April 1, 2014 to - December 31, 2020
[4] Ibid.

total of 1,070 TRR applications denied[5]. Most TRR approvals are for short-stay services. TRR approvals are based on type of service[6]:

| Total Number of TRR approvals April 1, 2014 to December 31, 2020 | Long-Term Care | Assisted Living | Home Support | Short-Stay | Total Cumulative |
|---|---|---|---|---|---|
| | 5,286 | 1,060 | 4,410 | 6,881 | 17,637 |

- 75% 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].

| Exceptions to TRR policy April 1, 2014 to December 31,2020 (all HAs combined) | Ineligible clients (e.g. MSD client) | Non-Standard Income Docs. | Incomplete Expense Docs. | Adjusted effective date | Other | Total Cumulative |
|---|---|---|---|---|---|---|
| | 65 | 2,591 | 2,485 | 2,628 | 2,463 | 10,232 |

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

February 26, 2021 –Christine Voggenreiter, ED, Integrated Analytics: Community & Cross Sector, HSIAR
March 9, 2021 – Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
March 16, 2021 – Danielle Prpich, ED, Community Care Support Services obo Teri Collins, ADM, Health Services Division

[5] Ibid.
[6] Ibid.
[7] Ibid.

# FACT SHEET

# Introduction of a New Non-Medical Model for Gender Change

## ISSUE

- The *Vital Statistics Act* requires all requests for gender change be accompanied by a statement from a physician or psychologist confirming that the sex designation on the applicant's birth registration does not correspond with the applicant's gender identity.
- In Canada, several jurisdictions have introduced a model where this medical sign off is no longer required.
- BC has not yet determined whether it will continue to require medical sign off or how it will be applied where the applicant is a minor.

## KEY FACTS

- Prior to the implementation of a non-medical model, a determination must be made on whether the waiver of physician/psychologist confirmation will be applicable to:
    - adult applicants only;
    - adult applicants and minor applicants between 12 and 19; or
    - all applicants, with no age restrictions.
- A briefing note was sent to the Minister of Health on June 12, 2020 for a decision on which cohort to apply the waiver to.
- While each jurisdiction in Canada has different age restrictions for the requirement for medical sign off, they all continue to require medical sign off **for minors**.
- Health Insurance BC and the Insurance Corporation of BC will align their policies with whichever non-medical model the Minister of Health approves.
- Section 27(3) of the Act provides the authority for the Minister of Health to waive the requirement for a physician or psychologist sign off, on a case-by-case basis.
- To avoid the administrative burden this would place on the Minister, delegation of this authority to the Registrar General (RG) of the Vital Statistics Agency is an option until the Act is revised. A briefing note was sent to the Minister on June 12, 2020 for a decision as to whether the Minister will sign off all the waivers or delegate his authority to the RG.

Background

- A joint ministerial initiative approved a two-phase approach to recording gender change in BC.
- The first phase of this initiative was the introduction of Gender "X", which was implemented on November 1, 2018. Gender "X" is now available on BC birth certificates to individuals who do not identify as male or female.
- The second phase of this initiative is to determine how a new model can be implemented where the requirement for physician or psychologist confirmation is no longer required.
- The current model under the *Vital Statistics Act* requires all requests for gender change be accompanied by a statement from a physician or psychologist confirming that the sex designation on the applicant's birth registration does not correspond with the applicant's gender identity.
- To date, Vital Statistics has not received any complaints about the requirement to have sign-off by a physician or psychologist.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

January 20, 2021 - Jack Shewchuk, RG, Vital Statistics Agency, Health Sector Information, Analysis and Reporting Division
February 26, 2021 - Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

# LEGISLATIVE SESSION - FACT SHEET

## Physician Services Expenditure

### TOPIC

- Expenditures for physician services include a number of sources:
  - Fee-for-Service;
  - Alternative Payment Program;
  - Population Based Funding;
  - Medical On-Call Availability Program;
  - Rural Programs;
  - Targeted Funding and Incentives (e.g., General Practice Services Committee, Specialist Services Committee, Shared Care Committee, Joint Standing Committee on Rural Issues);
  - Benefit programs for physicians and other payments.
- Physician expenditures grow (or decline) as a function of negotiated agreements, changes in physician supply, policy changes and changes in patient utilization of physician services.

### CURRENT SITUATION

- Over the 10 year period from 2010/11 to 2019/20, annual total Medical Services Plan sub-sub vote expenditures grew by $1.3 billion, from $3.6 billion (2010/11) to $4.9 billion (2019/20).[1]
- Payments for fee-for-service grew by an average annual rate of 3.1% from $2.5 billion in 2010/11 to $3.3 billion in 2019/20.[2]
- Over the same period:
  - Alternative Payment Program payments grew at an average annual rate of 4.5% from $376 million to $583 million.
  - Rural Incentive payments grew at an average annual rate of 5.1%, from $94 million to $158 million.

### KEY FACTS

Inter-Provincial Comparisons

- 2018/19 statistics (the most recently available comparable data) published by CIHI that compare fee schedule prices across Canada show that BC ranked 5th highest in average fees after Alberta, Quebec, New Brunswick, and Manitoba.[3]
- As of 2018/19, BC had the 6th highest payment per physician full-time equivalent (gross clinical payments) in Canada at $383,049. This is behind Alberta ($446,378), Manitoba ($418,017), Quebec ($414,019), Saskatchewan ($412,317), and New Brunswick ($400,929), with the BC average slightly lower than the Canadian average of $383,806[4]

### FINANCIAL IMPLICATIONS

- In 2020/21, the budget for physician services is $4.708 billion, an increase of 7.5% over the 2019/20 budget of $4.378 billion.[5]

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[1] Unaudited BC Public Accounts numbers, 2019/20.

[2] Health Sector Information Analysis and Reporting Division, Integrated Analytics: Primary Care, Acute Care and Workforce, Physician Resource Report (page 9) (base year 2010/11: PV = =$2,542,000,000; FV=3,342,000,000, N=9, then =4.5%)

[3] Physician Services Benefits Rate Report, 2018/19, Canadian Institute for Health Information, Table 1.1, 2018/19 https://secure.cihi.ca/estore/productSeries.htm?pc=PCC979 .

[4] National Physician Database, 2018/19, Data Release, Canadian Institute for Health Information, Table 1 https://secure.cihi.ca/estore/productSeries.htm?pc=PCC476

[5] Ministry of Health, Medical Service Plan budget excluding Supplementary Benefits, Midwives Services, OOP/OOC, Nurse in Practice and Nurse Primary Care.

# LEGISLATIVE SESSION - FACT SHEET

**Table 1: 2019/2020 Physician Services Expenditure by Category[6],[7]**

| Category | Expenditure (Millions) | | Proportion of Total | Increase over 2018/19 |
|---|---|---|---|---|
| Medical Fee for Service | $ | 3,057 | 68.04% | 4.87% |
| Alternative Payments Program | $ | 583 | 12.98% | 12.33% |
| Targeted | $ | 405 | 9.01% | 12.81% |
| Medical On-Call Availability Program | $ | 127 | 2.83% | (0.78%) |
| Rural | $ | 158 | 3.52% | 69.89% |
| Benefits | $ | 163 | 3.63% | 2.52% |
| **Total** | **$** | **4,493** | **100.00%** | **7.08%** |

- Physician services expenditure accounted for approximately 21% of Ministry of Health expenditures in 2019/20[8].

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**Approved:**
February 17, 2021 – Eric Larson, ED, Health Sector Information, Analysis & Reporting Division
February 22, 2021 – Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division
February 24, 2021 – Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

[6] Unaudited BC Public Accounts numbers, 2019/20.
Please note that this table has been revised to exclude laboratory services, which are now under a separate budget.
[7] Targeted includes General Practice Services Committee, Specialist Services Committee, Shared Care Committee, Physician Information Technology Office, Primary Blended Sites, Primary Care Sites Fort St John and Laboratory Re-investment.
[8] Unaudited BC Public Accounts numbers, 2019/20. A small portion of physician compensation is funded through health authority global budgets and not captured in these figures. Health authorities are not required to report this number.

# LEGISLATIVE SESSION - FACT SHEET

## Physician Supply Numbers

### TOPIC

- Understanding Health Human Resource (HHR) physician supply is critical to identifying pressure points on the healthcare system. Once identified, the Ministry of Health can implement strategic policy and plans to address BC's aging workforce and increasing healthcare demands.
- BC's goal of distributing medical education throughout the province is to help prepare future doctors for the challenges and benefits of practicing in rural, remote and underserved communities; enhance health care service capacity across the province (these residents in training provide direct patient care); and encourage these physicians to establish a practice in the communities where they are educated and trained.
- Primary sources of physician data are the BC Ministry of Health and the College of Physicians and Surgeons of BC (CPSBC).

### CURRENT SITUATION

- Compared to other provinces, BC has a good supply of physicians and growth in supply continues to outpace population growth.
- In 2019, according to CIHI, BC's ratio of physicians to population was third among Canadian jurisdictions, comparable to that of Alberta and Quebec and higher than the national average of 241 per 100,000[1]
- BC is increasing its self-sufficiency in physician training, while remaining an attractive destination for physicians relocating from other jurisdictions.
- Currently, the number of first-year positions at the University of British Columbia (UBC) postgraduate medical education (PGME) residency program has expanded from 134 in 2003 to 346 positions today.

### KEY FACTS

**Physician Counts**

- In 2019/20, the Ministry counted 12,695 physicians under all Ministry payment sources.[2] Physicians receive compensation through fee-for-service (65%), alternative payments (7%) or a combination of the two (28%).
- CPSBC data identifies 14,007 full registrants, 13,257 of whom are professionally active. This count exceeds the Ministry's as there is a subset of practicing physicians in the province who are not compensated through the public health system.[3]
- Other available sources of physician data include the Canadian Medical Association and the Canadian Institute for Health Information (CIHI). Physician counts derived from these sources may vary due to differences in the way data is collected, organized and reported on.

**Physician Supply**

Comparison

- In November 1999, the Canadian Medical Forum Task Force, representing a number of organizations and co-chaired by the President of the CMA and the President of the Association of Canadian Medical Colleges, endorsed a ratio of 180 to 190 physicians for every 100,000 people.[4]
- The ratio of physicians to population was 250 per 100,000 British Columbians in 2019.[5]

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[1] Ibid,4. - Verified by HSIAR

[2] Integrated Analytics - Primary Care, Acute Care and Workforce, Health Sector Information Analysis and Reporting Division, February 2021. Note that the alternative payments do not include physicians paid out of health authority global operating budgets.

[3] Annual Report 2019/20, British Columbia College of Physicians and Surgeons, https://www.cpsbc.ca/about-us/annual-report - Verified by HSIAR

[4] Task Force on Physician Supply in Canada, Canadian Medical Forum Task Force, page 3, Nov 22, 1999, http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.555.5035&rep=rep1&type=pdf - Verified by HSIAR

[5] Canadian Institute for Health Information (CIHI). Supply, Migration and Distribution of Physicians in Canada, 2019: Data Tables. Retrieved February 2021 from: https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34 - Verified by HSIAR

Challenges

Discussion of physician shortage is likely less related to the total number of physicians and more likely related to changes in productivity and availability. The CIHI report *Physicians in Canada, 2019* found that both the total number of physicians and the number of physicians per capita in BC increased between 2015 and 2019.[6]

- The physician workforce has grown consistently over the past decade.
- According to CIHI, the number of physicians increased by 16.9% from 2015 to 2019 more than doubling the 6.2% growth in BC population over the same period of time. [7]
- 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 2019, the average physician age in BC was 49.5 years.[8]

Training

- The University of British Columbia (UBC) postgraduate medical education (PGME) residency program has expanded and been distributed.
    - This expansion focused on training more generalists and primary care physicians. As a result UBC now has the largest single family medicine program in Canada, with 170 entry-level positions offered annually, for a total 340 trainees within the two-year program at any one time.
    - Expansion to 346 reached steady state in 2016. As residents move through years two to seven of their respective PGME training programs, BC will begin to realize the benefits of this unprecedented generalist/primary care training investment.
- Residents selected into one of the 58 IMG residency positions (52 positions in family medicine; 6 in Royal College specialties) must complete a Return of Service (ROS), usually in a rural/remote or underserved community. A resident completing a Family Medicine specialty is required to complete a 2-year ROS, and 3-year ROS if practicing in a Royal College specialty[9].

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 12, 2021 - Eric Larson, Integrated Analytics Primary Care, Acute Care and Workforce
February 24, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 26, 2021 - Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

[6]CIHI. Physicians in Canada, 2019. Retrieved February 2021 from: https://www.cihi.ca/sites/default/files/document/physicians-in-canada-report-en.pdf. - Verified by HSIAR
[7] Ibid 4 - Verified by HSIAR
[8] Ibid, 4 – Verified per HSIAR
[9] Workforce Planning and Development Branch, Health Human Resources and Labour Relations Division, Ministry of Health, February 2019..

# LEGISLATIVE SESSION - FACT SHEET

## Summary of Family Physician Supply in BC

### TOPIC

An overview of the supply of family physicians (FPs) in BC, including programs to educate, recruit and retain FPs.

### CURRENT SITUATION

- The primary sources of data to produce physician counts in BC are the Ministry of Health and the College of Physicians and Surgeons of BC (CPSBC). Other sources of data, including the Canadian Institute for Health Information (CIHI), are useful for drawing comparisons with other jurisdictions.
- As of 2019, BC's ratio of 131 FPs to 100,000 population was higher than the Canadian average of 122 per 100,000 and increased by 7.4% from 122 per 100,000 in 2015 to 131 per 100,000 in 2019.[1]
- Since the early 2000s, first-year PGME positions at the University of British Columbia (UBC) have more than doubled, increasing from 134 to now over 346 positions annually.

### KEY FACTS

- In the 2019/20 fiscal year, 6,642 FPs and emergency medicine FPs (52% of all physicians) received payment from the Ministry for providing patient care services.[2] This corresponds closely to the number of FPs registered through CPSBC during the same time period.[3]
- According to CIHI data, the total number of physicians, including FPs, increased by 16.4% from 10,917 in 2015 to 12,757 in 2019[4] which is more than double the 6.2% growth in the BC population over the same time period.[5] In the 2019/20 fiscal year, there were an additional 87 international medical graduates (IMGs) and 9 Canadian medical graduates (CMGs) granted provisional registration as family practitioners.[6]

Postgraduate Medical Education (PGME)

- PGME positions at the University of British Columbia (UBC) are:
  - Aligned with Ministry's key priorities and BC's workforce needs, UBC continues to maintain a strong focus on training generalists and primary care physicians.
  - By expanding to offer over 170 entry-level training positions annually (or 340 trainees within the two-year program), UBC now has the largest single Family Medicine program in Canada.
  - As residents move through their respective residency programs, BC will continue to realize the benefits of the Ministry's significant investment into PGME training.
- UBC's undergraduate and PGME programs have been distributed across the Province to:
  - Expose and prepare Family Medicine and other 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 residents also provide direct patient care while they train.
  - Upon completion of PGME, encourage these newly licensed physicians to establish a practice within the communities where they have been educated and trained.
- Residents selected into UBC IMG positions must complete a Return of Service (ROS), in a health authority-identified underserved community upon finishing their residency program.
  - There are 58 entry-level IMG positions: 52 positions in Family Medicine and 6 in Royal College specialties that include Pediatrics, Psychiatry and Internal Medicine.
  - Family Medicine and Royal College residents complete 2 and 3-year ROS terms respectively[7].

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[1] CIHI, Supply, Distribution and Migration of Canadian Physicians, 2019: Data Tables. Retrieved electronically on February 8, 2021 from: https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34

[2] Health Sector Information Analysis and Reporting Division, Integrated Analytics: Hospital, Diagnostic and Workforce, February 2021.

[3] CPSBC, 2019/20 Annual Report. Retrieved on February2021 from https://www.cpsbc.ca/about-us/annual-report .

[4] *Ibid 1.*

[5] CIHI has more historical physician data readily available than the Ministry. Hence the use of CIHI trends here. CIHI counts physicians by location on December 31, 2017. Ministry of Health counts physicians who received payment for patient care in the fiscal year; hence the slight difference in totals.

[6] Ibid, 2.

[7] Workforce Planning and Development Branch, Health Human Resources and Labour Relations Division, Ministry of Health, February 2019.

- ROS commitments are generally served within a rural, remote and underserved community, and are therefore helpful with addressing physician maldistribution.

Practice Ready Assessment for Internationally Trained Physicians

- 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).
- The Program's curriculum includes a two week centralized orientation in Vancouver before undergoing a 12-week Clinical Field Assessment under the supervision of a fully licensed FP in a BC community.
- PRA-BC is funded by the Joint Standing Committee on Rural Issues (JSC), a joint partnership between the Ministry of Health and Doctors of BC, to help address access to rural FPs in BC by requiring successful applicants to provide a 3 year Return of Service (ROS) in a rural community of need. The JSC has committed funding for up to 16 candidates per year for rural ROS placements.
- The Ministry of Health has committed an additional $1.15M in funding for up to 16 candidates with a priority given to Primary Care Networks (PCNs).
- As of February 19, 2020, 126 IMGs have successfully completed the PRA-BC Program, and have been placed in 45 rural BC communities.[8]
- PRA-BC graduates have been placed in 45 ROS communities across BC as follows: Northern Health: 51; Interior Health: 41; Island Health: 26; and Vancouver Coastal Health: 6; and Fraser Health: 2.[9]

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

March 8, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services

March 10, 2021 - Eric Larson obo Martin Wright, ADM, Health Sector Information Analysis and Reporting Division

[8] Physician Services Branch; Health Sector Workforce and Beneficiary Services Division, Ministry of Health. (2020*).* PRA-BC Evaluation Report. Data as of February 19, 2020.

[9] Workforce Planning and Development Branch, Health Human Resources and Labour Relations Division, Ministry of Health, March 2019.

# LEGISLATIVE SESSION - FACT SHEET

## 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.
- "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, through the use of video technology."

### CURRENT SITUATION

- Currently there are 217 Virtual Care fees for a variety of medical specialties in the MSC Payment Schedule[1].
- There are also 10 fees originally established under the General Practice Services Committee (GPSC) and 8[2] fees originally established under the Specialist Services Committee (SSC) that relate to telephone or email consultation and fall into the broader definition of "Virtual Care". These fees were transferred to the MSC Payment Schedule April 1, 2020, pursuant to the Physician Master Agreement.
- In 2020 since the outbreak of COVID-19, 25 new Virtual Care fees have been temporarily approved to support access to healthcare and 6 virtual care fees temporarily deleted to accommodate the changes. In addition, 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.

### KEY FACTS

- 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, the requirement that all telehealth visits must occur at a health authority facility was removed from the MSC Payment Schedule in 2011.
- Since then the Ministry of Health has seen significant increases in utilization, primarily in the GP telehealth fees.
- Wider adoption of other virtual care services and technologies has also resulted in steady growth across other physician specialties.
- The majority of physician virtual care visits were delivered through use of private, internet-based service providers.

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

| | FISCAL YEAR | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2015/2016 | | 2016/2017 | | 2017/2018 | | 2018/2019 | | 2019/2020 | |
| | Expend-iture ($M) | Services | Expend-iture ($M) | Services | Expend-iture ($M) | Services | Expend-iture ($M) | Services | Expenditure ($M) | Services |
| MSC Fee Items | $3.63 | 71,862 | $5.26 | 95,058 | $7.35 | 122,130 | $10.28 | 163,692 | $46.85 | 916,098 |
| GPSC Fee Items | $9.30 | 539,256 | $9.98 | 576,031 | $13.05 | 708,939 | $16.67 | 862,036 | $18.19 | 948,928 |
| SSC Fee Items | $11.42 | 278,906 | $16.23 | 387.312 | $15.37 | 387,857 | $16.37 | 423,288 | $18.23 | 475,028 |
| **Total GPSC/SSC** | **$20.72** | **818,162** | **$26.21** | **963,347** | **$28.42** | **1,096,797** | **$33.04** | **1,285,324** | **$36.42** | **1,423,956** |

[1] Medical Services Commission Payment Schedule. Retrieved from: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msc-payment-schedule-march-2019.pdf
[2] Ministry of Health. HealthIdeas fee item database.
[3] Ministry of Health Data are for fiscal years 2015/2016 to 2019/2020 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 MSC Payment Schedule effective April 1, 2020.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Total Broader Virtual Care** | **$24.35** | **890,024** | **$31,47** | **1,058,405** | **$35.77** | **1,218,927** | **$43.32** | **1,449,016** | **$83.27** | **2,340,054** |
| **Percent Year-Over-Year Increase** | | | 29.3% | 18.9% | 13.7% | 15.2% | 21.1% | 18.9% | 92.2% | 61.5% |

- Virtual care has played an important role during the COVID-19 pandemic. 2019/2020 MSP data indicates[6]:
  - The total of the broadly defined virtual care expenditures in 2019/2020 were $83.27 million, an increase of 92.2% ($39.95 million) from 2018/2019 ($43.32 million).
  - Of this total, $46.85 million (56.3%) was billed to virtual (including Video technology) fee codes under the MSC Payment Schedule, with $36.42 million (43.7%) to GPSC and SSC fee codes for telephone and email consultation.
  - MSC virtual care expenditures saw an increase of 355.7% from $10.28 million to $46.85 million from 2018/2019 to 2019/2020.
  - Due to the outbreak of COVID-19, MSC virtual care expenditure in Quarter 4 of 2019/2020 was $36.24 million, 77.3% of annual total.
  - In 2019/2020, 47.8% of the expenditure ($22.39 million) under MSC was for "Telehealth GP In-office Visit", with 89.8% from Quarter 4 of the year, an increase of over 13-fold from $1.53 million in 2018/2019.
  - GPSC/SSC fee codes for telephone and email consultation saw an increase of 10.2% ($3.38 million) from 2018/2019 to 2019/2020.
  - For the GPSC Fee codes, 79.2% of the expenditure ($14.42 million) was for "Family Physician (FP) Patient Telephone Management Fee," an increase of 8.9% ($1.18 million) over 2018/2019.
  - For SSC Fee codes in 2019/2020, 51.6% of the expenditure ($9.41 million) was for "Specialist Telephone Advice-Response within 2 hours", an increase of 11% ($0.93 million) from 2018/2019.
- Due to COVID-19 pandemic, virtual care expenditures have increased exponentially for January to September 2020 (2019/20 and 2020/21) compared to the same period in 2019 (2018/19 and 2019/20):
  - Virtual care fee item visits and consultations increased from less than 1% of all visits to 46.6%.
  - Expenditure of virtual care visits and consultations grew to $445.9 million from $8.7 million
  - Virtual care visits and consultation services increased from 137K to 8.9 million
  - 2.7 million patients visited 9,300 physicians via virtual care from 77K patients visited 1,800 physicians virtually.
  - In-person visits and consultations decreased by 44%; services of FP in-person visits and consultations decreased from 13.1 million to 6.4 million.
  - FP virtual care services saw the greatest increase[7]:
    - 8,940% growth in MSP services, from 80,000 to 7.3 million,
    - 5,621% growth in patient counts, from 44,000 to 2.5 million, and
    - 490% growth in participating physicians, from 879 to 5,182.

## FINANCIAL IMPLICATIONS

The total of the broadly defined virtual care expenditures in 2019/20 were $83.27 million, an increase of 92.2% ($39.95 million) from 2018/19 ($43.32 million) – largely due to COVID 19.

**Approved:**

January 28, 2021 - Eric Larson, Health Sector Information Analysis and Reporting
February 4, 2021 - Martin Wright, ADM, Health Sector Information Analysis and Reporting
February 8, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division
February 24, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services

[6] Ministry of Health System Information, Analysis and Reporting Division Integrated Analytics: Primary & Acute Care and Workforce Branch, Medical Services Plan Database, extracted October 2020.
[7] Ibid 6.

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# LEGISLATIVE SESSION - FACT SHEET

# 1-833 Get Vaccinated Call Centre

## TOPIC

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.

## CURRENT SITUATION

- In February and March 2021, the health authorities separately contracted with TELUS for call centre agents to supplement their regional call centres to assist citizens seeking to book their COVID-19 vaccination appointments.
- With the launch of the provincial digital platform (ImmsBC) for online registration and booking on April 6, the Ministry worked with TELUS and the health authorities to consolidate these regionally managed call centres into a single, expanded provincial service called the 1-833 Get Vaccinated Call Centre. TELUS is the prime service provider with additional support from call centre agents provided by IBM.
- TELUS and IBM call centre agents provide high volume registration and booking services for the ImmsBC vaccine management platform for citizens who require assistance with these processes.
- ServiceBC and Maximus provide specialised support services for the 1-833 Get Vaccinated Call Centre including translation support, creation of personal health numbers, telephone call-back services, and in-person support at ServiceBC locations throughout BC. ServiceBC and Maximus agents are also able to complete the entire registration and booking process for those calls that they handle.
- Although there were challenges experienced early on (March 8) that attracted public attention and criticism of TELUS' performance, the relationship with, and service levels provided by TELUS, have significantly improved. The Ministry and TELUS have put in place strong governance processes to manage TELUS' service delivery. Senior staff members within the Ministry and TELUSare in near daily contact to ensure call centre performance and services remain strong.

## KEY FACTS

- **Call Centre Number**: The provincial call centre number is 1-833-838-2323. It is toll-free in Canada and USA.
- **Call Centre Hours of Operation:** The call centre operates from 7am to 7pm, 7 days per week except statutory holidays. Statutory holiday hours are 9am to 5pm.
- **Call Centre Services**: TELUS provides registration and booking services for English speakers. Service BC and Maximus provide additional services, including translation (in excess of 110 languages are supported), the ability to create new PHNs for those citizens that require one, and telephone call-back services. ServiceBC (Maximus) has also supported specialist queues for Frontline workers and dedicated Punjabi- and Hindi-speaking lines.
- **Call Centre Agent Pool Size:**
  - On April 6th TELUS was able to provision over 2,500 call centre agents to handle the launch of the service. Numbers have reduced since that time in line with demand and vary considerably over the course of a given day or week. Typically, there are up to 800-900 concurrent agents at peak times on weekdays.
  - ServiceBC, through its service delivery partner, Maximus, averages 180 concurrent agents during weekdays.
  - All TELUS, IBM, and Maximus call agents are located in Canada.
- **Call Statistics:**
  - Daily call volumes have been highly variable since the launch of the service, in the range 8,000 (on Sunday, 18 April) to 67,000 (on Monday, 31 May) calls per day. Call volumes have been strongly influenced by public announcements.
  - In the month of May, TELUS and IBM handled over 946,000 calls with an average speed to answer of 14 seconds and average handling time (call duration) of just under 5 minutes.

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

The actual costs (as of June 6, 2021) from the Ministry's service delivery partners for the 1-833 Get Vaccinated Call Centre are as follows:

| TELUS | March 20 – April 31 |
|---|---|
| Government Financial Information | |
| | |
| | |
|

# LEGISLATIVE SESSION - FACT SHEET

# CareConnect New User Onboarding

## TOPIC

- Primary and community care providers and practitioners require increased access to shared clinical information to provide appropriate patient care when operating within the primary care networks and team-based health care model envisioned by the Primary Care Strategy.
- The COVID-19 pandemic has increased the urgency to provide these practictioners with virtual access to clinicial information.
- Onboarding additional primary and community care practitioners to CareConnect provides an efficient and secure means to enable appropriate access to shared patient information.

## CURRENT SITUATION

- For years now, CareConnect access has been made available to approximately 45% of physicians in BC through Electronic Medical Records (EMRs) using the private physician network (PPN).
- In December 2020, a more secure and cost effective alternative Internet pathway was developed by Provincial Health Services Authority (PHSA) to provide access for Providers who have not been using PPN.
- In addition, the Ministry has launched a project to develop governance, provide oversight and implement a plan to provide prioritized access to CareConnect to an additional 10,000 new users based on COVID-19 and Primary & Community Care needs as outlined in the Ministry's Primary Care Strategy.

## KEY FACTS

Strategic Drivers

- The objective of the system-wide Primary Care Strategy, initiated in 2018/19, is to put in place an integrated, well coordinated system of team-based primary and community care across the province. Use of technology for health information sharing between providers and practitioners was recognized as critical for enabling effective and quality person-centred care.
- The Digital Health Initiative Digital/IMIT Enablement business case emphasized the importance for team-based primary care providers to have access to comprehensive longitudinal patient records. Continuing the rollout of CareConnect to primary and community care providers and practitioners across BC was a recommended priority.
- COVID-19 has accelerated the need to efficiently share clinical information with team-based primary and community care practitioners who may be working virtually such as those supporting HealthLinkBC's 8-1-1 line.

CareConnect

- CareConnect is a secure, view-only Electronic Health Record that delivers patient-centric information to support health care providers in their delivery of patient care.
- CareConnect offers authorized health care providers 24/7 access to an integrated, provincial view of clinical information including encounters, lab results, imaging information, clinical documents including community clinical documents, immunization records, registration information and medications.
- CareConnect, initially implemented by Vancouver Coastal Health Authority, is now widely used within six Health Authorities, with over 66,000 healthcare professionals enrolled.

CareConnect Deployment to Primary and Community Care Providers and Practitioners:

- CareConnect was deployed by the Provincial Health Services Authority to over 300 primary care physicians and medical office assistants operating within physician-led private practice clinics in the Vancouver Coastal Health Authority vicinity.
- New CareConnect community user requests have been received from:
    - *Physicians* including virtual physicians supporting Ministry of Health programs such as HealthLInkBC 8-1-1 line. These virtual physicians do not have a previous relationship with the patient and require quick and efficient access to patient records to understand the patient's health history and make the best clinical

decision. Also requesting access are private practice physicians who would need to access CareConnect through a secure internet pathway as they are not on the Physician Private Network.

- *Pharmacists* registered with the College of Pharmacists of BC who have requested access as they need to obtain quick online access to patent histories to deliver safe and appropriate care, as they are are increasingly being asked to administer immunizations and provide interim prescriptions.
- *Community Specialist Providers & Community Health Team Members* who see new patients through virtual care and in the community. They have requested onboarding to CareConnect as they require quick and efficient access to patient records to understand the patient's health history, avoid duplicate lab testing, identify other providers in the circle of care and facilitate referrals.
- *Allied Health Professionals* including chiropracters, midwives, physiotherapists, occupational therapist and others governed by BC colleges, who have requested onboarding to CareConnect as they require quick and efficient access to patient health records to enable team-based care. CareConnect access will help to Zeffectively incorporate allied health professionals into the coordinated circle of care.

*NOTE: A QUESTION WAS RAISED TO THE MINISTER DURING THE FALL 2020 ESTIMATES DEBATE RELATING TO THE BC CHIROPRACTIC ASSOCIATION'S REQUEST TO ACCESS IMAGING TEST RESULTS FOR THEIR PATIENTS. ACCESS WOULD ASSIST IN STREAMLINING PATIENT FLOW AND MINIMIZING WAIT TIMES FOR PATIENTS. THE MINISTER'S RESPONSE REFERENCED PLANS TO EXTEND CARECONNECT ACCESS TO REGULATED HEALTH CARE PROFESSIONALS NOT AFFILIATED WITH A HEALTH AUTHORITY AS A WORK IN PROGRESS THAT COULD POTENTIALLY ADDRESS THIS NEED.*

- Prioritizing new-user access to CareConnect will be based on COVID-19 and Primary & Community Care needs as outlined in the Ministry's Primary Care Strategy.

## FINANCIAL IMPLICATIONS

Total 2020/21 CareConnect expenditures for the Ministry and PHSA were approximately $436,000 in operating costs and $335,000 in capital costs for initial implementation and web access.

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**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
April 23, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Clinical & Systems Transformation Project Update

### ISSUE

Completion of the Clinical & Systems Transformation (CST) project -- a joint initiative of Vancouver Coastal Health (VCH), Provincial Health Services Authority (PHSA) and Providence Health Care (PHC) to rollout the CST Cerner system and related practice changes -- over the next four years and in line with June 2020 capital and operating funding allocations.

### CURRENT SITUATION

- Since September 2020, the CST project has continued to deliver new COVID-19 functionality in the system to support live sites and also helped stand up the 10th CST Cerner-based testing site. The first VCH-Vancouver urgent primary care centre (UPCC) will roll out CST Cerner in February 2021.
- PHC's remaining long term care sites (Brock Fahrni and Langara) are slated to go live in late February 2021. BC Cancer's initial CST go-live at Vancouver Centre in planned for summer 2021 followed by Children & Women's Health Centre of BC (C&W) go-live in fall 2021. BC Cancer – Vancouver system design is complete and ready for testing. Communication, staff engagement and other important people readiness activities are in full swing; technical readiness preparations, including external lab integration work, are in hand; and the team is working hard to complete go-live planning.
- In early March 2021, BC Cancer will roll out CST pharmacy supply chain technology at Prince George, and is targeting to take its second centre live in fall 2021. Meanwhile, C&W has completed the initial rollout of Tap & Go technology (for single sign-on) with design, technical readiness work, communication to staff and providers, and detailed planning now ramping up further.
- These two major and concurrent implementations remain a top priority for 2021.

### KEY FACTS

Implementations to Date

- April to October 2018 – Successful site activations at Lions Gate Hospital, Squamish General Hospital, the Pemberton Health Centre and the Whistler Health Centre were achieved, with all sites tracking well against key indicators of successful adoption.
- October 2018 – Cerner Radnet (for Medical Imaging only) was implemented at R.W. Large Memorial Hospital in Bella Bella and Bella Coola General Hospital.
- November 2018 – Cerner Radnet was implemented at Sechelt Hospital (for Medical Imaging only) and Powell River General Hospital (screening mammography only).
- November 2018 – CST introduced sepsis alerts as part of new Cerner clinical information system.
- November 2019 – CIS went live at three large acute care sites at Providence Health Care (St. Paul's Hospital, Mount St. Joseph Hospital, Holy Family Hospital rehab) along with long-term care facilities at Holy Family and Mount St. Joseph Hospitals.
- December 2019 – BCMHSUS' Burnaby Centre for Mental Health and Addictions went live.
- September 2020 – BCMHSUS' Heartwood Centre for Women; and Providence Health Care's Youville tertiary mental health and long-term care and Langara tertiary mental health facilities, as well as St. John Hospice and Honoria Conway assisted-living, start using CST Cerner.
- October 2020 to January 2021 – stood up several more CST Cerner-based testing sites with VCH and PHC (for a total of 10). Other successful go-lives include a wave of Providence Health Care (PHC) ambulatory clinics in October 2020 with another cycle in late January 2021.

Background - Past Project Milestones:

- April 2013 – CST Project begins with IBM.
- March 2015 – Health organizations and IBM agree to end contract.
- April – September 2015 – Project reset completed, with assistance of PriceWaterhouseCoopers.
- July 2015 – Cerner retained as new project partner.
- October 2015 – Replanning phase initiated with Cerner.
- February 2016 – Design/Configure/Validate project phase started.

- April 2016 – Review and re-planning work completed.
- August 2016 – New Regional Pharmacy Production Centre completed, move-in in September.
- October 2016 – Review initiated of progress on Design and Configure, and project structure.
- December 2016 – Implementation at Group 1 sites delayed, in part to allow the project to incorporate recommendations made in the November 2016 Cochrane Review of IHealth, including the importance of ensuring that physicians and clinicians are actively involved in system design, configuration and validation.
- January 2017 - new clinical governance structure established to enable increased engagement by the clinical community to ensure strong clinical oversight of the project and involvement in decision-making.
- July 2017 – Design and configuration of initial version of new clinical information system is completed and system testing begins, including clinical validation of end-to-end workflows.
- August 2017 – the CST Project Board established early 2018 as new target for system activation target for the first Lions Gate/Sea-to-Sky group of sites.
- December 2017 – Wynne Powell appointed as Chair of the CST Project Board and Special Advisor on the project to the Minister and Deputy Minister.
- March 2018 - Cerner's readiness assessment confirmed that all CST applications were properly configured in preparation for system activation.
- April 2018 – Loading of 740,000 patient records into the new system was completed preparatory to system activations later in the month.
- January 2019 – CST Project Chair, CEOs of VCH, PHSA and PHC, and CST Chief Transformation Officer reached a mutual decision to transition to a new CTO to lead the CST Project. Work to complete a Project Assessment to confirm the status of current work was also announced and launched.
- February 2019 – New CST CTO announced; CTO leadership transition occurred relatively seamlessly.
- Spring 2019 – Project Assessment was completed; CST Project Board approved updated CST roadmap (including site sequencing and resource requirements), and accepted zero-based, bottom-up cost model output as the project's go-forward baseline spend and resource forecast tool.
- Summer 2019 - Cerner upgrade across VCH-Coastal sites completed, CST Cerner rolled out at Lions Gate Hospital and Sea to Sky for allied professionals in social work, dietetics and spiritual care, and rolled out Clinical Collect in Lions Gate Hospital's ICU.
- November 2019 - St. Paul's, Mount Saint Joseph and Holy Family hospitals, went live with CST Cerner impacting 8000+ care providers and the 110,000+ patients served annually.
- December 2019 - PHSA's first CST project activation at Burnaby Centre for Mental Health and Addiction.
- December 2019 – design/build of new CST Cerner CIS estimated to be 90% complete.
- March-August 2020 – diversion of resources to support VCH, PHSA and PHC's COVID-19 efforts.
- June 2020 – temporary shift to an interim CST work plan (CST deliverables that could continue).
- August 2020 – CST project board approved a return to the full CST project roadmap with contingency planning underway to help future-proof CST implementations against COVID-19 impacts.
- September 2020 – BCMHSUS' Heartwood Centre for Women and Providence Health Care's Youville tertiary mental health and long-term care and Langara tertiary mental health facilities, as well as St. John Hospice and Honoria Conway assisted-living, start using the CST Cerner.

## FINANCIAL IMPLICATIONS

In June 2020, additional provincial capital and operating funding for the CST project was approved based on an extended implementation timeline (over four years). Funding adjustments are described below:

- additional capital contribution of $221.6M, increasing total provincial capital contribution to $701.8M
- additional operating funding of $181.0M. The operating funding is intended to address the CST project's one-time, software, and hosting costs and includes $45.25M in 2020/21, and notional approval for the remaining $135.75M million over the remaining four years.

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**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IMIT Division
February 21, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Contact Tracing and Case Management

## TOPIC

Minimizing COVID-19's resurgence depends on the speed and completeness of case contact tracing. Successful contact tracing depends on: (i) capacity of Public Health contact tracing staff to manage cases and contacts; (ii) ability to aggregate all relevant data and perform necessary population health analytics; (iii) degree of completeness of the tracing of contacts of individual cases; and (iv) ability to provide additional protection for particular groups at higher risk of exposure.

## CURRENT SITUATION

- The Ministry of Health, working with the Provincial Health Services Authority (PHSA), BC Centre for Disease Control (BCCDC) and health authorities, is actively developing digital tools to improve the Province's contact tracing capabilities, which fall broadly into two categories of solutions:
  - The first type of solutions supports our Public Health workforce to perform clinical case management, contact tracing, and epidemiological study.
  - The second type of solutions are citizen-facing digital apps and tools that are intended to augment manual contact tracing efforts and support the safety of citizens in their day-to-day interactions.
- Work underway includes 4 key initiatives:
  1) Deploying a Provincial public health solution to enhance efficiency of clinical care providers, contact tracers and epidemiologists;
  2) Standardizing on Panorama and the Ministry's Health Data Platform as the provincial systems for aggregating all available public health data;
  3) Using the Health Data Platform to deliver advanced public health analytics functions; and,
  4) Deploying a digital dashboard to provide contact tracers with a single source of positive cases and a service to enable citizens to receive COVID-19 test results by text messaging.

Cabinet Confidences; Intergovernmental Communications

## KEY FACTS

Advice/Recommentations; Intergovernmental Communications

Public health digital tools

- Until recently, BC's health authorities have been using multiple clinical systems for case and contact management. Many required the significant use of paper and spreadsheets often with duplicate, even triplicate, data entry requirements within disparate systems. This caused significant, unsustainable strain and impact on scarce public health resources working at the front lines of communicable disease management, e.g., COVID-19.
- In August 2020, extensive engagement with Public Health Medical Health Officers and contact tracers across all the regional health authorities and BCCDC was undertaken to understand the then-current situation and challenges faced by Public Health. Following the extensive engagements, the Ministry and PHSA committed to co-create a provincial 'inhouse' solution that fully meets the needs of Public Health.
- Functional gaps limit the broad adoption of Panorama (user interface) as a provincial solution to handle case management and contact tracing. As a result, alternatives were sought to support this urgent need.
- Fraser Health Authority (FHA) has implemented a custom case and contact management module in its PARIS EMR, and Vancouver Coastal Health Authority (VCH) has implemented a case and contact management solution from the London Middlesex Health Unit in Ontario. These two health authorities are managing ~85% of all COVID-19 cases in BC.
- Vancouver Island Health Authority (VIHA) started using the same case and contact management solution as VCH in December. Additional health authorities are exploring onboarding onto this solution. In parallel, work is being done on the shared VCH and VIHA solution to further enhance its capabilities, building on the very positive impact achieved to date.
- Panorama is positioned as the single provincial repository for public health data. Data feeds to Panorama are being added from the provincial case and contact tracing solution (including FHA and VCH implementations) to ensure all reportable data is electronically submitted to Panorama.

## FINANCIAL IMPLICATIONS

In 2020/21, the Ministry has provided the health authorities with funding of up to $46.8 million to hire additional staff for contact tracing and committed $2.381 million to fund the purchase and implementation of the case and contact management solution.

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**Approved:**
February 17, 2021 – Corrie Barclay, ADM, Health Sector IM/IT Division
April 20, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
April 20, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Digital and IMIT Investment Strategy and Roadmap

## TOPIC

Alignment of health sector digital and IMIT investments across the province is required in order to address fiscal constraints while improving the health and quality of care for citizens.

## CURRENT SITUATION

The Ministry of Health is working with health sector organizations to develop a 10-year digital and IMIT investment strategy and roadmap to improve the efficiency and sustainability of our health system.

## KEY FACTS

- BC's health system needs to change significantly if it is to consistently provide both quality and affordable health services. The Province has developed a strategic vision for a person-centred and integrated health system in BC. Digitization of health services is a critical component of this transformation and enables new ways to deliver services efficiently and effectively.
- The Digital Health Strategy guides the digital transformation of BC's health sector. The COVID-19 pandemic has accelerated the use of digital technologies and highlighted demand for digital health.
- The current approach to IMIT investments across publicly funded BC health organizations is largely organization-centric with some efforts towards common investments for shared needs. This approach is no longer appropriate nor sustainable. To advance the Digital Health Strategy, a provincial approach to addressing common and shared digital and IMIT services is required.
- Work has been initiated to better understand the health sector digital and IMIT investments required to sustain services and enable sector-wide transformation. A focus on digital and IMIT investments will:
  - Enable integration of health system investments to address fragmentation and advance a well-coordinated system of care;
  - Address fiscal constraints by providing an improved understanding of IMIT capital requirements and operating expenses to optimize investment opportunities;
  - Facilitate coordination and improved decision-making across all types of capital investment (i.e., digital IMIT, facilities, equipment); and
  - Better align digital and IMIT investments with Ministry and health sector priorities.
- During winter 2019/20, the Ministry engaged with health authorities to establish a baseline of current funded and unfunded health sector capital and operating projects. The Ministry will continue to collaborate with health authorities to update this baseline and develop the 10-year digital IMIT investment strategy and roadmap.
- The digital and IMIT investment strategy and roadmap aligns investments to the Digital Health Strategy. It is aimed at consolidating information technology services across the province in a phased manner where it makes sense to achieve standardization, leverage economies of scale and resources, reduce risk of duplication, and increase interoperability of applications and services across health organizations. This work also supports the development of new approaches to continue to strengthen and enhance capital infrastructure processes and management of IMIT infrastructure.

## FINANCIAL IMPLICATIONS

Government Financial Information

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**Approved:**
February 17, 2021 – Corrie Barclay, ADM, Health Sector IM/IT Division

# LEGISLATIVE SESSION - FACT SHEET

# Digital Health COVID-19 Response Portfolio

## TOPIC

The Ministry of Health has established a provincial Digital Health COVID-19 Response Portfolio to manage new digital initiatives being launched during the COVID-19 pandemic.

## CURRENT SITUATION

- The provincial Digital Health COVID-19 Response Portfolio is led by HSIMIT in partnership with the Provincial Health Services Authority (PHSA) and close collaboration with the BC Centre for Disease Control (BCCDC), health authorities, and sector stakeholders. The portfolio reports directly to the ADM for HSIMIT.
- The Digital Health COVID-19 Response Portfolio efforts are focused on:
  - Providing trusted information and self-assessment guidance from government and public health to citizens through the BC COVID-19 Support App and COVID-19 Digital Agent (Chatbot), thereby relieving the burden on critical resources such as HealthLinkBC;
  - Ensuring citizens have timely access to their COVID-19 lab results and vaccine records through Health Gateway and secure texting services;
  - Deploying a new vaccine management platform to support the rollout of the COVID-19 vaccine to the general population, which digitally enables citizen registration and scheduling, vaccine administration, supply chain/inventory, and reporting;
  - Implementing new contact tracing and case management tools to reduce COVID-19 transmission; and,
  - Implementing online applications to allow residents and foreign workers to document their self-isolation plans upon entry to BC.

## KEY FACTS

As of January 2021, the Ministry is working with our health sector partners to implement several digital solutions.

- ***COVID-19 Vaccine Digital Platform:*** See separate fact sheet for details on this system which is being deployed to support BC's COVID-19 Immunization Plan.
- ***COVID-19 Contact Tracing and Case Management:*** See separate fact sheet for details on the digital solutions being implemented to support contact tracing and case management in BC.
- **Access to COVID-19 Lab Results:** COVID-19 inpatient/outpatient lab results are now available and distributed to patients and providers via several channels: the Provincial Health Gateway, myEHealth patient portal, VIHA's Patient Portal, IHA's Patient Portal, the BCCDC negative results line and the SMS texting service. The Health Gateway provides both e-mail and mobile text notification of new results in real-time.
- **Single Site Staffing**: A website built to assist the BC Health Staffing Initiative to support a centralized staffing approach being coordinated by the Provincial Health Office and the Ministry of Health that will limit the movement of staff between worksites.
- **BC COVID-19 Support App & Website:** Provides trusted information about COVID-19 to citizens. The built-in Symptom Self-Assessment Tool provides health education and recommendations to help people decide if COVID-19 testing and self-isolation is needed. In collaboration with BCCDC, clinical content on the website/app and the Self Assessment tool are updated regularly to align to the latest public health guidelines. The Self-Assessment Tool is available in 8 languages, i.e., Arabic, Farsi, Traditional Chinese, Korean, Punjabi, Hindi, French and English. In December 2020, the app was enhanced to allow citizens to send anonymously any symptoms they are experiencing to Public Health, enriching the data set used to further study epidemiological trends and virus spread based on reported symptoms and severity. In January 2021, immunization related resources were added to the mobile app to provide information to the public regarding the provincial vaccination roll-out, and also, the needs of Immunizers was supported by adding information regarding vaccine administration. There is also functionality to scan QR codes displayed at local businesses to view their COVID-19 safety plans. This feature was built in partnership with Ministry of Jobs, Economic Recovery and Innovation.

- **COVID-19 Digital Agent (Chatbot):** The COVID-19 Digital Agent uses artificial intelligence and machine learning to match conversations and provide quick answers to citizens' questions related to COVID-19, with the intention to divert call volumes from resources such as HealthLinkBC's 8-1-1. The agent presented a new channel for helping citizens and providing a view to the public's interests, concerns and priorities about the pandemic. This tool, first launched on the BCCDC website, has been expanded to BC Gov, HealthLinkBC, BC Cancer Agency and Interior Health COVID-19 websites.
- **Returning Traveller Online App/Form:** A web-based Self-Isolation Plan has been deployed to ensure all travellers are complying with public health orders, which require returning international travellers to self-isolate for 14 days.
- **Temporary Foreign Worker Online App/Form:** Similar to the returning traveler program, this app -- created in partnership with the Ministry of Agriculture and Service BC -- helps BC farmers be ready for receiving their foreign workers and ensuring a safe workplace aligned to infection control protocols.
- **Health Careers Access Program:** A web-supported service to match those seeking employment in the health care sector with employers in need of health care support workers and health care assistants.

COVID-19 digital tools will continue to play an active role in BC's response to the pandemic, and will be enhanced, refined and more widely deployed across BC throughout 2021.

## FINANCIAL IMPLICATIONS

The table below shows the funding approved for FY20/21 and requested for FY21/22. It does not list actual costs incurred by these initiatives.

| | 2020/21 Approved Funding | | 2021/22 Funding Requested | |
|---|---|---|---|---|
| **Initiative Name** | **Capital** | **Operating** | **Capital** | **Operating** |
| COVID-19 Digital Agent (Chatbot) | $472,747 | | $569,040 | $248,000 |
| COVID Lab Results | | $59,855 | | |
| Temporary Foreign Worker Online App/Form | | *Funded by EMBC* | | $100,000 |
| Returning Traveller Online App/Form (Self Isolation) | | *Funded by EMBC* | $249,000 | $125,000 |
| Single Site Staffing | $871,788 | $125,325 | | |
| Health Careers Access Program | $602,337 | | $600,000 | $185,000 |
| BC COVID-19 Support App & Website (Thrive App) | | $700,000 | | $0 |
| COVID-19 Contact Tracing | $1,636,000 | $745,000 | $1,520,000 | $1,458,198 |

**Approved:**
June 11, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
June 15, 2021 – Brenda Rafte obo Philip Twyford, ADM, Finance and Corporate Services Division
June 15, 2021 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

# Digital Health in Rural and Remote British Columbia

## TOPIC

Digital health has a critical role to play in enabling and empowering providers and patients in rural and remote areas to improve access to health information, access to primary care and specialized health services through available and emerging technologies.

## CURRENT SITUATION

- The Ministry of Health (HLTH) and the health authorities are placing increased focus on delivering care in the home and in local communities, providing better access to care for those living in rural and remote communities so they can stay at home, finding ways to improve long-term care, and increasing the quality of care delivered.
- Opportunities to gain efficiencies by learning from and replicating health care innovations, such as virtual care, remote monitoring and enhanced decision support are being pursued.

## KEY FACTS

- Through the cross-sector work across various strategic pillars of the Digital Health Strategy (See Digital Health Strategy Fact Sheet for additional details), the Province has made significant progress in ensuring the health sector collaboratively designs, implements, and increases access to numerous digital health services and tools.
- A large number of digital health tools and services have been made available in response to COVID-19 (See COVID-19 related Fact Sheet for more details).
- Some of the Digital Health initiatives that benefit Rural and Remote areas are:
    - *Provider Toolkits & Support for Virtual Health*
      Doctors of BC's Doctors Technology Office (DTO) and PHSA's Office of Virtual Health have published Virtual Health Toolkits for community and Health Authority providers. The toolkits provide an overview of multiple virtual consult tools, a comparison of the tool capabilities, and detailed guidelines on safe and effective use of each tool. The DTO also established a peer physician network through weekly webinars and ramped up support to triage and address provider questions.
    - *Home Health Monitoring (HHM)*
      The existing HHM program was expanded to most regional health authorities for COVID-19 case and contact monitoring, i.e., patients designated as case positive, case probable, contact (no symptoms) and contact (symptoms). HHM provides safe and efficient care to patients at home and within the community, thereby helping to suppress viral transmission. Leveraging the HHM technology has allowed limited pools of clinical resources to manage and monitor a larger volume of COVID cases/contacts.
    - *Shared EMR to support real-time virtual support (RTVS) physician pathways*
      In response to COVID-19 and to support rural and remote patients and providers, HLTH and Rural Coordination Centre of BC have established RTVS physician pathways, which are pools of on-call physicians who either interact directly with patients or support rural/remote primary care providers in specialized areas such as emergency, intensive care, maternity, pediatrics.
    - *Mental Health and Substance Use Virtual Clinics*
        - HLTH, and Ministry of Mental Health & Addictions, in collaboration with partners at BC Children's Hospital, Foundry[1] and BC Emergency Health Services (BCEHS), are developing Mental Health and Substance Use Virtual Clinics to support both at-risk youth aged 12 to 24 years suffering from mild-to-moderate mental health and substance use issues, and BCEHS paramedics and dispatchers experiencing occupational stress injuries.

[1] Foundry Fact Sheet: Foundry is a network of centres and e-health services co-created with health and social service partners, young people and families in communities within BC. The sites are intended to improve mental health, substance use and primary care access, navigation and care for youth and young adults in communities across B.C.

- Virtual clinics, such as those being deployed by Foundry, provide tools and resources of benefit to rural communities, including:
  - ✓ Confidential messaging and videoconferencing for patient-to-provider and peer-to-peer communication
  - ✓ A patient-owned personal health record for capturing, storing and sharing their health information with care providers and family
  - ✓ Curated clinical content including videos on topics specific to needs
  - ✓ Moderated education forums
  - ✓ Self-management tools like health trackers, assessments and action plans

- *Province-wide deployment of CareConnect*
  - We are pursuing the province-wide deployment of CareConnect, the Provincial eHealth viewer (portal), for Providers to access patient information held by Health Authorities.
  - To enable this, work is underway to identify network limitations in rural and remote communities and to develop solutions to address access-related issues.
- *Innovation Hub Project, South Okanagan Similkameen*
  - As part of the Innovation Hub Project in the South Okanagan Similkameen:
    - ✓ A technical foundation is being laid to allow documents to be shared between Health Authority facilities with community Primary Care Networks – including enabling electronic referrals to be sent from a patient's Electronic Medical Record (EMR) within a primary care clinic to the regional hospital.

## FINANCIAL IMPLICATIONS

- In Fall 2019, a business case describing HLTH's digital health initiatives was drafted. Outlined in the business case is a list of over 50 digital capabilitiesm, to digitally enable Primary, Community, and Specialist Care throughout the province. The digital capabilities were validated with Providers and some patients at sessions held in urban, rural and remote communities across BC.
- The Ministry allocated up to $$29.8 million in 2020/21 to support the virtual services associated with the Rural Remote Collaborative Framework. The costs to address actual services provided will not be know until the 2020/21 fsical year has ended and final audited financial information becomes available.

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**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
February 23, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Digital Health Strategy

### TOPIC

- BC's Digital Health Strategy (DHS) provides the vision and foundation for the health sector's digital transformation to create a sustainable health system that promotes health and wellness for all British Columbians.
- Developed in collaboration with a wide range of sector stakeholders, the DHS comprehensively lays out a vision for the systematic digital transformation of the BC health sector. This digital transformation will be a fundamental enabler of our health system's ongoing effectiveness.

### CURRENT SITUATION

- BC is continually having to balance sometimes-competing demands of improving the quality of health outcomes and overall service experience, effectively and efficiently allocating available resources, and ensuring equitable distribution of services across the Province. This means providing services centred on the person, providing access to safe and appropriate services that meet the needs of patients and their families, ensuring efficient and effective delivery of these services and analyzing our performance so we can continually improve, all within the constraints of steadily growing demand and finite available resources.
- In response to this transformation imperative, the Province has developed a strategic vision for a person-centred and integrated health system in BC. Digitization of health services is a critical component of this transformation journey, enabling new ways to deliver services efficiently and effectively, allowing patients to both self-manage and be more involved as a partner in their own care, allowing patients and providers to be connected in real time, and providing thoughtful analysis for improved patient care, system planning, research and policy development.

### KEY FACTS

- COVID-19 has accelerated the work outlined in the DHS (see COVID-19 Fact Sheet).
- **Co-Created** - The DHS has been co-created by BC health sector leadership, led by the Ministry of Health, using a collaborative approach to identify how digital health can empower citizens, patients, families and caregivers, and care team members.
- **Mission** - Co-create an integrated and sustainable health care system that delivers improved health outcomes and embraces a culture of innovation, trust, and partnerships.
- **Goals** – The purpose is to digitally transform care delivery within BC's health care system in support of provincial priorities to create an integrated and coordinated health care system. The DHS has the following key goals:
    - Patient-Empowered Experience – ensuring the future patient experience is personalized, placing patients at the centre of their care and empowering them to proactively manage and make decisions about their health, wellness and care.
    - Integrated System of Care – integrating our future health care system in a way that connects and enhances collaboration and communication across care teams and the care continuum such that ccitizens can experience care that is more accessible and of higher quality.
    - Valued Care Team Experience – our health care professionals are integral to our health care system and need access to tools that support access to information, documentation, care delivery, collaboration and decision-making in a way that makes their work easier and more efficient and enhances their overall work experience.
    - Enhanced Decision Support – at the core of health care is data and its ability to support evidence-based decisions. Advanced analytics will support system-wide planning and population health management to improve health outcomes, optimize processes and inform policies in addition to supporting better care for individuals and quality improvement activities of practitioners and care teams.
- **Five Strategic Pillars** - Needed capabilities within the DHS fall under five strategic pillars with specific initiatives are underway within each of these pillars.
    1. Empowering patients;

2. Transforming primary, specialists and community care;
3. Transforming hospital-based care;
4. Advancing analytic capabilities; and
5. Enhancing shared clinical systems such as pharmaceutical, laboratory and digital imaging.

- **Scope** - The scope of the DHS is comprehensive, including patient empowerment tools, community and hospital-based care, and analytics. The combination of this scope and the DHS' goals is intended to create a digital environment that supports providers and administrators to deliver on the Institute for Healthcare Improvement's Triple Aim of improving the health of populations, enhancing the experience of care for patients and providers, and reducing the per capita cost of health care.
- **Intended Outcomes** - The DHS will foster an environment where systems from multiple vendors can effectively work together through conformance with underlying foundations of common architecture, infrastructure, standards and policy, much like the utilities beneath a city. We refer to this as our "ecosystem". Through such an ecosystem, existing and future patient and provider tools will be able to better work together to realize these benefits:
  - From the patient's perspective, this will mean the ability to access and contribute to their health information, collaborate with their care team, access care when and where they need it, and take control of their own health and wellness. In support of these objectives, the ecosystem approach will greatly facilitate the development of patient tools that are interoperable with other health system tools to provide citizens a fulsome picture of their health journey
  - From the provider's perspective, this will mean enhanced collaboration with the patient and the wider care team that crosses boundaries of geography and electronic systems, support for making better decisions for both individuals and populations, widespread use of data to continually improve quality and efficiency, and tools to help translate learnings into practice.
  - From the technologist's perspective, the ecosystem approach will accelerate innovation, encourage competition by reducing vendor lock-in and enabling many vendors to contribute to the ecosystem, and lower the barrier to entry for specialized new solutions by enabling them to work with existing infrastructure.
- The strategic elements in the DHS will guide further planning, decisions and actions including ensuring measurable outcomes that align with the DHS' vision, mission and goals for the BC health sector around digital health.
- It is further anticipated all aspects of clinical or business strategy going forward will be informed by digital considerations as embodied in the DHS.
- A Digital Health Collaboration Office has been created within the Ministry under the leadership of the Health Sector Information Management and Information Technology Division to support integrated digital health governance and implementation of initiatives.
- The focus for 2021/22 is on moving forward with initiatives to enable patient empowerment and primary, specialist and community care, while also establishing a strong health sector governance, policy, and technical foundation for the delivery of digital health in BC.

## FINANCIAL IMPLICATIONS

- Funding and planning to implement DHS initiatives is underway, and a coordinated investment approach is being pursued to ensure alignment, prioritization and sustainability of these initiatives through a 10-year health sector digital and IMIT strategy and roadmap.
- Funding approval in 2019/20 was $3.3M
- Funding approval in 2020/21 was $2.7M

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**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
April 6, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Electronic Medical Record Systems Enhancement

### TOPIC

Work to increase the value of primary care providers' Electronic Medical Record (EMR) systems and to enable information sharing between these EMRs both in the community and in Clinical Information Systems used by health authorities.

### CURRENT SITUATION

- There are several initiatives underway in BC to improve access to information through EMRs, namely: Clinical Document Exchange (CDX); secure access to view patient information; population-based funding; electronic prescribing; electronic forms; and, health standards to increase information exchange (see "Key Facts" section for specifics).
- Next steps include:
  - Updating a roadmap of current Ministry EMR capabilities and their anticipated EMR vendor community engagement timelines to inform the development of an EMR vendor strategic plan.
  - Developing a sector-wide EMR strategy and vendor engagement plan to better coordinate EMR priorities and integration with EMR vendors.

### KEY FACTS

EMR definition, purpose and BC implementation challenges:

- An EMR is a computer-based patient record specific to a single clinical practice[1]. EMRs have the potential to be key enablers of multidisciplinary team-based care and wider health sector transformation where patient health information is available where and when it is needed regardless of where it is held.
- While 94% of all full scope family practice and community specialist physicians below standard retirement age had adopted an EMR[2], enabling the exchange of health information with community-based providers has proven challenging as:
  - There has been no common incentive models to motivate EMR vendors to enhance their products.
  - EMR vendor capacity, service delivery maturity and application robustness vary.
  - Physicians may be disincented to adopt new functionality because it can lead to increases in their EMR licensing and on-support charges.
  - The Ministry of Health and the health sector have not engaged EMR vendors with a common set of priorities, standards and application enhancement requests.

Initiatives to Improve Physician Access to Patient Information through EMRs:

- **Population Based Funding** (PBF) – is a blended capitation compensation model that better supports the implementation of team-based care; and supports increased access, flexible care options, and greater patient attachment. To enable PCNs and to promote increased patient attachment, HLTH is engaging with vendors on the development of the PBF compensation model; making it available to approved PCN communities to support the implementation of PCNs.
- **Electronic Prescribing** (e-Prescribing) – allows prescribers to order and send prescriptions electronically to a patient's local pharmacy of choice for immediate access. Through PharmaNet's integration with EMRs, the e-Prescribing functionality will be implemented to enable a digital record of prescriptions in PharmaNet and to improve the overall processes for prescribers and pharmacies while assuring the authenticity of prescriptions.
- **Electronic Forms** – The Electronic Forms repository includes establishing a new electronic repository for authoring and deploying forms and requisitions used in community and acute settings and will leverage the CDX system to electronically submit completed forms to recipients that will enable processing without manual data entry. Two EMR vendors are currently working on integration with the eForms repository.

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[1] Canada Health Infoway, 2019

[2] BC Provincial and IHA EMR Adoption Report – April 2015

- **Clinical Document Exchange** - Clinical Data eXchange (CDX) is a joint initiative between Interior Health and Northern Health to support secure two-way electronic distribution of personal health information and communications. A small pilot project to expand the CDX system is underway through joint projects with HLTH, Interior Health and South Okanagan Similkameen under the Innovation Hub (see the Innovation Hub factsheet). This pilot is testing secure two-way exchanges of eReferrals, eConsults, and the sharing of clinical communications across the care team.
- **Secure access to view patient information** - Vancouver Coastal Health has enabled access to a eHealth viewer called CareConnect to a number of community physicians in their region. A larger project to enable access of up to 10,000 users to CareConnect is underway (see the CareConnect Fact Sheet). The CareConnect onboarding project aims to provide a secure, view-only electronic health record (EHR) that delivers patient-centric information and offers authorized health care providers 24/7 access to an integrated provincial view of clinical information. With future integration with CDX, it will become possible for community practices to contribute content to CareConnect, such as clinical summaries and shared-care plans.

Health Standards to increase information exchange

HLTH and the health sector are working to increase the adoption of health information standards and increase health information exchange across the sector through the Digital Health Strategy (DHS). The DHS calls for prioritizing standardization and health information exchange initiatives, strengthening standards and EMR vendor governance, supporting a health information standards model, and establishing a vendor and physician incentive model. Progress to date includes:

- Establishing a provincial health information standards office.
- Implementing certain technical standards that are foundational for the exchange of clinical content between EMR systems and Clinical Information Systems.
- Strengthening governance over health information standards working with EMR vendors.

## FINANCIAL IMPLICATIONS

- A memorandum of understanding (MOU) between HLTH and the health authorities committed $430,000 per year from January 2018 to December 2019 for the development of health information exchange standards for use by EMR vendors and their clinical users to support electronic health information exchange.
- In April 2020, the MOU was extended for a further two years; committing $230,000 per year to lead sector development of harmonized, foundational privacy and security policies across the BC health sector, and to support HLTH/health authority operational privacy and security priorities, plus $200,000 per year to support engagement of contracted health informatics professionals and other resources.

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**Approved:**

February 17, 2021— Corrie Barclay, ADM, Health Sector IM/IT Division

April 6, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Federal Government Innovation Superclusters Initiative

### TOPIC

The BC Digital Technology Supercluster (BCDTS) is a collaboration between private companies, academia, and not-for-profit organizations to accelerate the growth of digital technologies in precision medicine, natural resources and manufacturing.

### CURRENT SITUATION

Through the Ministry of Health's (MoH) role on the BCDTS board and annual investment in the BCDTS, we are looking to inform project selection and advance priority initiatives in the B.C. health sector, including those responding to COVID-19.

### KEY FACTS

- In February 2018, the federal government announced it would invest up to $950M in five superclusters across Canada over the next five years, ending in 2022. The Superclusters include: Digital Technology (BC); Oceans (Atlantic Canada); SCALE.AI (Quebec); Advanced Manufacturing (Ontario); and Protein Industries (Prairies).
- The $152M federal government investment in BCDTS secured an additional $200M commitment from its initial cohort of 29 members, representing 33 organizations.
- To implement BCDTS, a not-for-profit society was created to oversee master project and industry service agreements and multi-party funding for the pan-Canadian initiatives. In addition, a board was created with representatives from the private, public and non-profit sectors.
- The Province is represented on the BCDTS board by the Ministry of Jobs, Economic Recovery and Innovation (JERI) as voting member and MoH as non-voting observer; the annual contribution of $1.5M is shared 50/50 by the two ministries.
- JERI is leading BC's participation and is working with MoH, cross-government, and industry teams to ensure that the BC Government's principles for participation and investment are met.
- MoH is working to leverage its board role and annual investment in the BC Digital Supercluster to inform project selection, facilitate alignment with MoH and health sector strategic vision and ecosystem architecture, and leverage federal and private sector funding for digital health initiatives identified by MoH and the health sector, including the COVID-19 response.
- BCDTS is funding projects in several programs through annual intake cycles between 2018/19 and 2022/23. To date, 13 projects have been funded in the precision health program. MoH is participating in an advisory capacity on four of these projects and is an observer on two projects.
- In March 2020, BCDTS announced $60M of its funds would be used to address the COVID-19 outbreak and build expertise and capacity to respond to future urgent situations. There are 35 COVID-19 projects valued at $108M ($60M from Supercluster and $48M from members). This program was completed in August 2020.
- The BCDTS has funded at least $164.8M ($73.7M from Supercluster and $91.2M from members) through its annual intake cycle, which includes program areas not directly related to health (see summary of health-related projects on page 2 of this Fact Sheet). All remaining federal funds are expected to be committed by March 2021.

### FINANCIAL IMPLICATIONS

- The Province has committed $1.5M annually from 2018/19 to 2022/23 for its BCDTS membership. MoH has committed to paying $750,000 of this annual cost for 2019/20 to 2022/23.
- Provincial funding supports the BCDTS Capacity Building Program ($1M for talent development for Indigenous and other under-represented groups, start up/small business scale-up, and commercialization and $500,000 for BCDTS operations).

# LEGISLATIVE SESSION - FACT SHEET

**Health-related BCDTS and COVID-19 Projects. More detail is available at digitalsupercluster.ca**

| Projects | Total Budget (Investment by BCDTS) | Description | MOH Role in Project |
|---|---|---|---|
| **2018/19, Cycle 1** | | | |
| Secure Health and Genomics Data Platform (SHGP) | $3.5M ($1.4M) | Build a secure pan-Canadian platform for genomics, health, and electronic health records. | ***MoH advisory role*** |
| Pharmacogenomics / Tailored Health | $4.7M ($1.2M) | Testing, analytics, physician training and data platforms for the development of pharmacogenomics. | ***No MOH role*** |
| Dermatology Point of Care Intelligent Network | $9.7M ($3.6M) | Digital technology to provide coordination and assistance for physicians involved in dermatology patient care path. | ***MoH observer role*** |
| **2019/20, Cycle 2** | | | |
| Personal Health Wallet | $1.4M ($545,000) | Self-sovereign health management of citizens' own health data and the ability to potentially share that data with third parties. | ***MoH advisory role*** |
| Opioid Management | $4.4M ($1.7M) | Integrates patient-reported outcomes and objective sensory data to optimize pain management provide actionable feedback to physicians. | ***MoH advisory role*** |
| Point-of-Care Ultrasound | $2.6M ($650,000) | Combines machine learning with handheld ultrasound to provide diagnostic capabilities and share ultrasound images with care teams. | ***MoH observer role*** |
| **2020/21, Cycle 3** | | | |
| Healthcare to Homecare | TBD, funding agreement in development | Precision medicine approach to monitor physiological metrics in frail patients to delay disease progression. | ***MoH advisory role*** |
| Workplace Brain Health | TBD, funding agreement in development | Creating personalized wellness strategies for employees to lead happier, healthier lives. | ***MOH role TBD*** |
| Autism Sharing Initiative | TBD, funding agreement in development | A federated data sharing network to provide better care for Canadians with autism. | ***MOH role*** *TBD* |
| Trustsphere | TBD, funding agreement in development | Identity management for citizen access to their own health data. | ***MOH role TBD*** |
| WayfindER | TBD, funding agreement in development | Machine learning to guide hospital patients to their destination and reduce emergency department traffic. | ***MOH role TBD*** |
| Wellness.AI | TBD, funding agreement in development | Voice recognition and wearable technologies to assess emotional state and wellbeing. | ***MOH role TBD*** |
| Optimizing Healthcare through applied Digital Twinning | TBD, funding agreement in development | Creating a digital/virtual copy of St. Paul's Emergency Department to optimize design and workflow, simulate operations and inform future construction | ***MOH role TBD*** |
| **COVID-19 Projects** | | | |
| 35 projects selected between March-July 2020 | $108M ($60M) | Focus areas include Health System, Community Health, Safe Living, Diagnostics and Therapeutics, and Emergency Response | |

**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IMIT Division
February 18, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Gateway

### TOPIC

- Health Gateway is a citizen-centred, web-based application that uses the mobile BC Services Card to provide users with secure and coordinated access to their health information and services from anywhere in the province.
- Health Gateway was developed by the Ministry of Health in partnership with the Ministry of Citizens' Services' Office of the Chief Information Officer, Government Digital Experience, and Provincial Health Services Authority.

### CURRENT SITUATION

- As of June 9, 2021, Health Gateway has over 192,000 registered users.
- Its functionality includes:
    - Level 3 Identity Assurance credential through secure login and registration through the mobile BC Services Card to the Health Gateway.
    - Immunizations (History and Forecast), including the COVID 19 Vaccine.
    - Prescription history.
    - Special authority request status.
    - The ability for users to capture information about their own health care experiences with notes and comments.
- Health Gateway is also being used to support the Province's COVID-19 response:
    - COVID-19 test results are available to BC residents (and includes parental access to COVID-19 results) enrolled in Health Gateway as soon as the results have been processed and reported on by the lab.
    - SMS and E-Mail notifications are sent when new results are available to be viewed securely.
    - Residents may view their immunizations and vaccinations, and forecasted dates for multiple doses. This includes the manufacturer, drug name, date, and lot number.
- Currently, residents need a mobile BC Services Card to use Health Gateway. As of June 9, 2021, over 575,000 residents have activated their mobile BC Services Card. As of June 2021, the approximate breakdown of activated mobile BC Services Cards by age category is:
    - Under 55 – 77%
    - 55-65 – 13%
    - 66-75 – 8%
    - 75+ – 2%

### KEY FACTS

<u>Strategic Context and Drivers for the Health Gateway</u>:

- The Digital Health Strategy (see Digital Health Strategy fact sheet) and Citizen Access Strategy -- developed by the Ministry of Health, the health authorities and other partner organizations from across the provincial health sector - identify the need for a provincial health "gateway" to provide patients with a secure, single online point of access into their health information and services. One of the key drivers for Health Gateway is to enable technology to deliver health care that ensures relevant and targeted health care information, both public and private, is provided to British Columbians in an effective and secure manner, and supports an "ecosystem" of citizen access applications.
- Patient portals provide citizens with online access to health information and services. While several private and public-sector health organizations are planning, or have implemented, patient portals across the province, these deployments to date remain limited to regional health organizations and/or information only available in local systems in physician offices, hospitals, pharmacies, and labs.

# LEGISLATIVE SESSION - FACT SHEET

Current Challenges being addressed by Health Gateway:

- **Fragmented access to health information** - Limited coordination or collaboration between health services and teams, among siloed services, and with various pieces of patient health information being distributed across multiple IM/IT systems -- leaving patients frustrated by their health information and services not being connected or coordinated as they try to navigate the health care system.
- **Security Risks** - There is also the growing privacy risk with patient health information being made available via multiple portals protected only by simple user-name and password combinations.

Health Gateway – Scope and Objectives:

- Health Gateway is a web-based application that was created to provide B.C. residents with a single view of their health information and services from anywhere in the province.
- Health Gateway objectives include:
  - Meeting citizens' demand for online access to health information and services.
  - Empowering patients to be active participants in their health care by providing access to their own health information when and where they want it.
  - Promoting an integrated system of health care by reducing information barriers.
  - Providing secure and seamless access to patient health information and services using the mobile BC Services Card.
  - Engaging directly with users of Health Gateway to continue to shape and evolve the app's user experience and design.
- Additional Health Gateway capabilities planned for the near future include: Lab Results, Hospital Visits, Diagnostic Imaging Reports, Delegation of Access (managed by the user), HealthLink Education Information, PharmaNet (Fair-PharmaCare Premiums, e-prescriptions and others), and integration with regional portals and other third-party applications.

## FINANCIAL IMPLICATIONS

In 2020/21 the Ministry spent approximately $1.929 million of the Office of the Chief information Officer Capital on Health Gateway.

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**Approved:**
June 11, 2021 - Corrie Barclay, ADM, Health Sector IMIT Division
June 14, 2021 - Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Division

# LEGISLATIVE SESSION - FACT SHEET

# Health Insurance BC (HIBC)

## TOPIC

The Ministry of Health's (HLTH) contract with Maximus BC to provide HIBC services is nearing end of term, and a re-procurement process is underway.

## CURRENT SITUATION

- The HIBC contract with Maximus BC will expire March 31, 2023 further to a recent 2-year extension to allow for completion of the re-procurement and an orderly transition to the next service provider.
- HLTH released a Joint Solutions Request for Proposals (JSRFP) for HIBC services on BC Bid on August 26, 2020. *NB: no public comment on this active procurement process should be made.*
- Timelines for the Procurement activities are as follows:

| | |
|---|---|
| Obtain TB Approval | April 2020 – Complete |
| Complete and Release JSRFP Documents | Aug 26, 2020 – Complete |
| Phase 1 - Stage 1 – 3 C's and Initial Concept due | Oct 21, 2020 – Complete |
| Phase 1 – Stage 1 - Down select to 3 proponents | Nov 13, 2020 - Complete |
| Phase 1 - Stage 2 Workshops complete | Dec 18, 2020 - Complete |
| Phase 1 - Stage 3 Concept complete – down select to 2 proponents | Feb 18, 2021 – In Progress |
| Phase 2 – Joint Solutioning – select successful proponent | June 21, 2021 |
| Phase 3 – Due diligence/Finalize solution | Oct 21, 2021 |
| Phase 4 – Contract Finalization/TB approval | Feb 22, 2022 |
| Transition | Mar 31, 2023 |

## KEY FACTS

HIBC Services

- HIBC administers medical coverage through the Medical Services Plan and drug coverage through the PharmaCare and Fair PharmaCare programs.
- HIBC also provides medical claims processing services to the Insurance Corporation of BC and WorkSafe BC.

Existing HIBC Contract and Planned Re-Procurement

- In November 2004, HLTH signed a 10-year, $324-million contract with Maximus BC to deliver HIBC services starting April 1, 2005. The contract was renewed in 2013 for a further five years beyond March 31, 2015, to expire March 31, 2020.
- An agreement to further extend the term to March 31, 2021 was signed in November 2018.
- An agreement to extend the current contract for HIBC services to March 31, 2023 was signed in July 2020, to allow for completion of the procurement and an orderly transition to the next service provider.
- HLTH is onboarding the HIBC beneficiary (citizen) contact centre services to the Service BC outsourcing contract for government-wide citizen contact centre services.
- A JSRFP for the HIBC services was released on BC Bid on August 26, 2020. Procurement considerations include HLTH's business and transformation priorities, and Government's strategic directions for procurement and digital transformation.

MAXIMUS BC

- The current service provider, Maximus BC, was incorporated in BC in 2002 and operates in Victoria, BC.
- Maximus BC is a subsidiary of Maximus Canada, which is a subsidiary of the US-based Maximus Inc. founded in 1975.
- Approximately 200 BC Government Employees Union (BCGEU) members were transitioned to Maximus BC when services commenced in 2005.
- Maximus BC now employs approximately 350 individuals in Victoria including approximately 254 BCGEU members. The unionized staff remain members of the BCGEU under a separate collective agreement.

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

The total 18-year (2005-2023) contract value is approximately $1.021 billion.

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**Approved:**

February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division

February 18, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Home Health Monitoring

## TOPIC

Through the Home Health Monitoring (HHM) initiative, the Province is enabling patients with moderate to highly complex chronic and episodic health conditions to self-manage their health from the comfort of their homes, using blue-tooth-enabled devices that communicate blood pressure and other health indicators to monitoring nurses in their local health authority.

## CURRENT SITUATION

- As part of the Province's COVID-19 response, HHM was expanded to all health authorities for case and contact monitoring of COVID-19, i.e., patients who are designated as case positive, case probable, contact (no symptoms) and contact (symptoms).
- The total number of patients who have been monitored to-date using HHM, including COVID-19 monitoring, is 15,201 (as of December 31, 2020).

## KEY FACTS

- To date, all but the First Nations Health Authority have participated in the HHM initiative. Current use includes:
  - Island Health: ongoing use of heart failure and chronic obstructive pulmonary disease (COPD) protocols; Chronic Kidney Disease and Hypertension interviews newly launched; new protocol development for patients with multi-morbidities and in palliative care; COVID-19 case and contact; plus, COVID-19 intensive monitoring; using HHM technology to support people with mild to moderate COVID-19, prioritizing populations most at risk of deterioration and poor outcomes.
  - Interior Health: ongoing use of heart failure protocol; participating in the Vancouver Coastal Health-led heart failure project; COVID-19 case and contact.
  - Provincial Health Services Authority: BC Emergency Health Services community paramedics provide home health monitoring support to seniors living at home in rural and remote communities (including a diabetes protocol); BC Cancer Victoria Head/Neck patients; BC Centre for Disease Control COVID-19 case and contact.
  - Fraser Health: implementation of COPD and planning for a multi-morbidity protocol; participating in Vancouver Coastal Health-led heart failure project; COVID-19 case and contact.
  - Northern Health: COVID-19 case and contact.
- The Ministry of Health (HLTH) is working with First Nations Health Authority to identify HHM options.
- Patients using HHM report being better able to manage their symptoms, decrease reliance on acute care resources, and highly satisfied with the service.
- Clinicians have also reported significant satisfaction levels with HHM.
- HLTH may extend the use of HHM to support the delivery of primary and community care.
- HHM is funded by HLTH and the Strategic Investment Fund (SIF) under the Strategic Relationship Agreement between TELUS and the Province. SIF "is aimed at strategic, ambitious IT projects that hold the promise of making significant impacts in the lives of B.C. citizens".

## FINANCIAL IMPLICATIONS

- SIF allocated $40 million to the HHM initiative and $39.16 million was spent by the end of 2020/21.
- Canada Health Infoway is providing $3.3 million to the Province, split between PHSA and HLTH[1]. Approximately $1.129 million in funding is being provided to HLTH for costs associated with HHM use for COVID-19.

[1] Canada Health Infoway "$3.3 Million in Funding will Support Virtual Health Care Across British Columbia During COVID-19 and Beyond." Published July 29, 2020 https://www.infoway-inforoute.ca/en/solutions/rapid-response-to-covid-19/5266-solutions/rapid-response-to-covid-19/8670-3-3-million-in-funding-will-support-virtual-health-care-across-british-columbia-during-covid-19-and-beyond

- HLTH, through its Health Sector IM/IT Division, is providing financial support for the HHM platform and the deployment, retrieval and rental of patient device kits. The 2020/21 operational expenditure was $2.33 million.[22]

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**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
April 14, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[2] Email communication, Paul Payne (Patient Empowerment Portfolio Lead, Digital Health Initiative, MOH), April 7, 2021

# LEGISLATIVE SESSION - FACT SHEET

# IHEALTH

## TOPIC

Completion of the IHealth project, Vancouver Island Health Authority's (Island Health) initiative to extend the reach and capabilities of its health-authority-wide Electronic Health Record (EHR) system, over the next five years and in accordance with June 2020 capital and operating funding allocations.

## CURRENT STATUS

With provincial capital and operating allocations now identified, Island Health is working on an implementation plan to guide the completion of IHealth based on scope over five years (2020/21–2024/25).

## KEY FACTS

Project Benefits Realization

- IHealth is an interactive information system that replaces paper charts and notes with electronic documentation.
- The EHR enables health care teams to instantly access and share information like lab results, medication history and care plans. Reducing the need to find, fax, and review patient files saves time for staff and helps them make the most appropriate care decisions for patients.
- Upon completion over the next five years, the project will include:
  - Advancement of the patient portal, community health services EHR, and implementation of the Cerner EMR in several primary care settings
  - full advanced EHR functionality, including Computerized Provider Order Entry (CPOE) being activated at four sites: Royal Jubilee Hospital, Victoria General Hospital, Saanich Peninsula Hospital, and Cowichan District Hospital; and,
  - a subset of advanced EHR functionality being activated across all acute care sites.
  - Island Health is committed to completing the scope across all acute sites.

Project Status and Achievements as at December 2020

**Table 1: Project Status by Workstream and Project Phase**

| Workstream | Planning | Design/Build | Implementation |
|---|---|---|---|
| 1. New EHR Platform | 100% | 100% | 100% |
| 2. Patient Portal | 100% | 90% | 80% |
| 3. Community Health Services EHR | 100% | 70% | 47% |
| 4. Primary Care EMR & EMR Connect | 100% | 100% | 65% |
| 5. Acute and Ambulatory Care EHR | 100% | 94% | 32% |
| 6. Long-Term Care EHR | 100% | 98% | 34% |

**Table 2: Activation Status by Workstream**

| Workstream | Locations Activated | # of Active End Users as at December 2020 |
|---|---|---|
| 1. New EHR Platform | 14 hospitals, 285 clinics,<br>18 Long Term Care facilities | 22,482 total, including providers, nursing, allied health and support staff |
| 2. Patient Portal | all Vancouver Island residents | 90,500 patients enrolled to date |
| 3. Community Health Services EHR | 18 CHS Offices and Programs | 1568 staff |
| 4. Primary Care EMR and EMR Connect | EMR – 11 practices; 3 UPCCs<br>EMR Connect – 221 practices | 1,143 staff (physicians, clinicians, clerical) |
| 5. Acute and Ambulatory Care EHR | Full functionality: 1 hospital<br>Partial functionality: 6 hospitals<br>Full functionality: 1 Ambulatory<br>Full functionality: 1 Urgent Care | 4,215 total, including providers, nursing, allied health and support staff |
| 6. Long-Term Care EHR | Full functionality: 2 facilities<br>Partial functionality: 2 facilities | 901 total, including providers, nursing, allied health and support staff |

# LEGISLATIVE SESSION - FACT SHEET

**Background**

Further to NRGH stabilization efforts and recommendations generated from the Ernst & Young and Cochrane Reports, Island Health Board endorsed a multi-year Go Forward Plan for IHealth that was developed through an interative consultation process with Island Health stakeholders.

Rebaselined Plan and Addressing NRGH Concerns

- Shortly after IHealth's activation in March 2016, NRGH physicians voiced significant concerns over the stability and safety of the new system, and some NRGH physicians reverted to using paper orders. An internal review by the Health Authority Medical Advisory Committee provided recommendations for improvement and collaboration, which were accepted by the Island Health Board; however, the NRGH Medical Staff Association (MSA) requested a third-party independent review.
- Dr. Douglas Cochrane was retained by HLTH in July 2016 to conduct an independent review of IHealth and end-user concerns. His report was released November 2016.
- A number of internal consultations with third party subject matter experts were also conducted.
- In September 2017, EY was engaged to confirm the then-current project status and examine continuing issues with IHealth; EY's report, released in January 2018, had nine recommendations – all of which were accepted.
- January 2018: Due to ongoing culture issues at NRGH, Minister Dix appointed two mediators (Jane Morley and Jean Greatbatch), tasked to work with Island Health and physicians and staff to develop a collaboration accord and EHR stabilization criteria.
- February 2018: An interim IHealth Project Board (Project Board), led by HLTH's Deputy Minister and Island Health's CEO, was established to augment the Island Health Board's oversight of IHealth and, specifically, to oversee the implementation of the nine EY recommendations.
- February-September 2018: The Project Board oversaw NGRH mediation process, Island Health's response to the EY IHealth recommendations, and IHealth project activities.
- Fall 2018: The Project Board received and endorsed a multi-year Go Forward Plan for IHealth that was developed through an iterative consultation process with Island Health stakeholders. Following the Project Board's approval of the Go Forward Plan, the Project Board was stood down, with oversight for IHealth transitioning back to the Island Health Board that, in turn, established an IHealth Task Force to provide a forum for continued, focused review of IHealth activities and risks.
- November 2018: Island Health Board requested a 2019/20 bridging plan be developed to ensure continued advancement of the EHR while additional funding to enable completion of the project was sought.
- Work undertaken in 2019, under the bridging plan, focused on advancing IHealth's five remaining workstreams: 1. Patient Portal; 2. Community Health Services EHR; 3. Primary Care EMR and EMR Connect; 4. Acute and Ambulatory Care EHR; and, 5. Long-term Care EHR.

**FINANCIAL IMPLICATIONS**

In June 2020, additional provincial capital and operating funding for the IHealth project was approved based on an extended implementation timeline (over five years) and reduced scope. Funding adjustments are as follows:

- an additional capital contribution of $54.6 million, increasing the total capital budget to $154.9 million (including $100.3 million from Island Health); and,
- additional operating funding of $49.42 million. The operating funding is intended to address the IHealth project's one-time, software and hosting costs, and includes:
  - $2.16 million in 2020/21; and,
  - notional approval for the remaining $47.26 million over the remaining four years.

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**Approved:**

February 17, 2021 - Corrie Barclay, ADM, HSIMIT Division

February 23, , 2021 - Kirk Eaton and Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Mental Health and Substance Use Virtual Clinic Project

### TOPIC

- The Province is developing two Virtual Clinic mobile-device applications (Apps) to increase access to Mental Health and Substance Use (MHSU) services for at-risk youth and paramedic/dispatcher employees in BC.
- The BCEHS "ShiftWell" and Foundry Virtual Apps have been developed in response to increasing demand throughout the province for mental health and substance-use content and services by both groups.

### CURRENT SITUATION

- Two distinct mobile applications have been designed and developed and are in pre-deployment testing on iOS and Android devices.
- With modern and intuitive design, both applications incorporate features such as live clinician chat, clinical content (articles, videos and podcasts) goal setting, scheduling and other tools co-designed by clinicians and users.
- Stringent privacy and security requirements and policies are being finalized to ensure all requirements are met or exceeded for both applications.
- Limited production roll-out for both mobile applications are underway, with the BCEHS "ShiftWell" App having launched in October 2020 and the Foundry Virtual App in February 2021.
- Foundry Virtual will also include a Web App for youths who do not have access to smart phones.

### KEY FACTS

- The Ministry of Health (HLTH) and the Ministry of Mental Health and Addictions (MMHA) have partnered with BC Children's Hospital, Foundry BC, and BC Emergency Health Services (BCEHS) to develop these "virtual clinic" applications to support individuals suffering from mild-to-moderate MHSU issues.
- The adoption of innovative virtual care technologies has the potential to transform how patients manage their mental health, interact with health care professionals and obtain the care and services they need.
- These mobile applications will provide youth connected to Foundry with easier access to clinicians and tools so they can 'tell their story once', and will provide paramedics and dispatchers with more direct access to trauma counselling through the BCEHS Critical Incident Stress Program.
- The virtual clinic applications will offer tools and resources such as:
    - A confidential chat service between youth and clinicians/peer support workers
    - Specially developed clinical content for youth, paramedics and dispatchers including articles, videos and audio podcasts
    - Schedule management tools to support development of self-care goals and action plans
- Comprehensive privacy and security reviews for both applications, including application penetration testing, has been completed.
- An anonymous benefits evaluation survey was conducted for the BCEHS "ShiftWell" application, yielding 70% positive sentiment rating of the application by early users.
- Partners at BC Children's Hospital, Foundry and BCEHS will evaluate the benefits and effectiveness of the Virtual Clinic applications and, if deemed appropriate, the mobile apps may be rolled out to additional patient populations.

### FINANCIAL IMPLICATIONS

- in 2020/21, capital funding of $783,000 was provided through the Strategic Investment Fund (SIF) to support the MHSU Virtual Clinic Project.
- In 2020/21, capital funding of $1.45 million was provided through COVID-19 Contingencies access to support Foundry Virtual mobile and web applications enhancements.

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**Approved:**
February 17, 2021 - Corrie Barclay, ADMr, Health Sector IM/IT Division
May 11, 2021 - Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# MOH and CGI Application Management Services Agreement

## TOPIC

The Ministry of Health's (HLTH) contract with CGI Information Systems and Management Consultants Inc. (CGI) for application management services, which commenced October 1, 2015.

## CURRENT SITUATION

- The initial contract term was from October 1, 2015 through December 31, 2020 but was recently extended to March 31 2021 to allow for negotiations for a two-year renewal term.
- Application management services are still required, and HLTH does not have the internal staff resources or budget to deliver these technical services.

## KEY FACTS

- Under this contract, CGI provides application maintenance services in support of approximately 115 HLTH business applications, tools and services; web development for HLTH's websites; and server management services for approximately 150 servers.
- The contract has a fixed-price component for base services covering break/fix support and a variable-price component that fluctuates with the assignment of on-demand services.
- On-demand services are services assigned on an "if, as and when requested" basis at the sole discretion of HLTH, and typically include application development and enhancements, adaptive and perfective maintenance, and the retirement of applications.
- The CGI contract[1] was signed on October 1, 2015, following the completion of a two-stage procurement process, which included a Request for Qualifications stage and a Request for Proposals stage. The five-year agreement allows for up to two, two-year renewal terms at HLTH's sole discretion.
- HLTH's Health Sector IM/IT Division manages the CGI contract, and intends to renew March 2021 for a two-year term (terms and conditions currently under negotiation).

## FINANCIAL IMPLICATIONS

Government Financial Information

- The current maximum for on-demand services that may be assigned under the contract is $56 million.
- The current total maximum value of the contract over five years including both base and on-demand services is $71.5 million.

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**Approved:**
January 21, 2021 - Muriel Zemliak, A/ED, IT Services Branch
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
April 6, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] CGI provided similar services to HLTH under the previous Application Support and Server Management Agreement between June 2006 and September 2015.

# LEGISLATIVE SESSION - FACT SHEET

# Office of the Auditor General 2018 Audit: IDIR Account Management

## TOPIC

The Ministry of Health's (HLTH) participation in an Office of the Auditor General cross-government IT audit focused on Internal Directory Identity Registry (IDIR) Account Management.

## CURRENT SITUATION

- HLTH, along with other selected ministries including the Ministry of Citizens' Services (CITZ), participated in the Office of the Auditor General (OAG) IDIR audit that was initiated in late 2017.
- Publicly released in August 2019, OAG's audit report is available through this link: https://www.bcauditor.com/sites/default/files/publications/reports/OAGBC_IDIR_Report.pdf.
- HLTH was found to be largely compliant (i.e., 4 out of 5 audit criteria areas) in the IDIR audit.
- Following the November 2019 Select Standing Committee on Public Accounts (SSCPA) meeting to review the IDIR audit findings and recommendations, along with the CITZ-led action plan to address OAG's recommendations, HLTH has completed its work to address the one area of non-compliance detailed below.
- As of December 31, 2020, the Internal Directory Identity Registry (IDIR) Account Management audit project is now completed and closed.

## KEY FACTS

- OAG's IDIR Account Management audit looked at whether "the five selected ministries and their related branches and agencies have design[ed] and implemented key controls as identified in 'Access Control' chapter of the *Government Information Security Standard'* for protecting government information and information assets from unauthorized access".
- HLTH's Information Technology Services Branch participated in the audit in August 2018 on behalf of the ministry.
- The audit had five lines of enquiry:
  1) **HLTH compliant** - Is there a formal provisioning process to assign IDIR accounts for all employees and contractors?
  2) **HLTH compliant** - Is there a formal process to link employees' and contractors' IDIR accounts to ministry applications and other related services?
  3) **HLTH compliant** - Is there a formal employee de-provisioning process to remove IDIR access for all employees and contractors and their related services?
  4) **HLTH compliant** - Is the use of privileged IDIR accounts restricted and controlled?
  5) **HLTH non-compliant** - Are ministries formally reviewing employees' and contractors' IDIR access rights at regular intervals to ensure their access rights are current and valid?
- OAG assessed HLTH as being compliant in four out of five audit criteria areas.
- HLTH has now addressed the one area of non-compliance, i.e., Item 5 above.

## FINANCIAL IMPLICATIONS

HLTH does not require technical resources or additional funding to implement the few recommendations in the IDIR audit due to our high level of compliance.

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**Approved:**
January 20, 2021 - Muriel Zemliak, Acting ED, IT Services Branch
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division

# LEGISLATIVE SESSION - FACT SHEET

## Office of the Auditor General 2018 Audit: IT Asset Management

### TOPIC

The Ministry of Health's participation in an Office of the Auditor General cross-government Information Technology (IT) audit focused on IT Asset Management.

### CURRENT SITUATION

- HLTH, along with other selected ministries including the Ministry of Citizens' Services (CITZ), participated in the IT Asset Management audit that OAG initiated in December 2017.
- OAG's final report was publicly released in January 2021, and is available here.
- HLTH was found to be partially compliant in all seven audit criteria areas.
- HLTH is participating in a CITZ-led action plan to address the findings of this audit.
- A presentation to the Select Standing Committee on Public Accounts (SSCPA) on the audit's findings and the action plan will be scheduled.

### KEY FACTS

Key Audit Findings and Background

- HLTH completed OAG's audit questionnaire of seven questions, looking at whether HLTH:
  1. Maintained an inventory of physical devices and systems under their responsibility.
  2. Maintained an inventory of software platforms and applications under their responsibility.
  3. Maintained maps of organizational communication and data flows.
  4. Maintained an inventory of information systems hosted by third parties.
  5. Periodically review IT Asset inventories.
  6. Prioritized IT assets under their responsibility based on classification, criticality and business value.
  7. Defined and established cybersecurity roles and responsibilities for the entire workforce and third-party stakeholders (e.g., suppliers, customers, partners).
- Branches contributing to HLTH's response included the IT Services Branch, Data Management and Stewardship, Health Information Privacy, Security and Legislation, Business Management Office, Vital Statistics Agency, and HealthLink BC.
- **Areas of improvement identified** - While OAG's audit recognized HLTH did maintain asset inventories (physical devices, applications and information systems), they identified areas for improvement including: clarifying roles and responsibilities, classifying assets by criticality/risk, capturing key asset information, and performing asset periodic review cycles.
- HLTH has pointed out to OAG that HLTH:
  - Does not have automated tools to detect unauthorized access by devices to the network or unauthorized software loaded onto IT assets.
  - Shares responsibility to manage IT asset inventories with CITZ.

### FINANCIAL IMPLICATIONS

The technical resources and funding needed by HLTH to comply with the recommendations in the IT asset management audit are in the process of being determined.

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**Approved:**
2021-01-20 - Muriel Zemliak, Acting ED, IT Services Branch
2021-02-17 - Corrie Barclay, ADM, Health Sector IM/IT Division

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Health Services Authority eHEALTH Services

### TOPIC

Provincial Health Services Authority's (PHSA) provision of operational support services for the following eHealth services:

- Private Physician Network (PPN)
- eHealth Network Gateway (eNG)
- Provincial Laboratory Information Solution (PLIS)
- Provincial Diagnostic Image Viewer (PDIV)
- Public Health Clinical and Surveillance Information System (Panorama)

### CURRENT SITUATION

The current Ministry and PHSA Master Services Agreement for the provision of eHealth services is set to expire March 31, 2021, and the Parties have begun exploring future negotiation activities for a new agreement.

### KEY FACTS

- BC's 2005 eHealth Strategic Framework included a portfolio of projects to improve access to critical health care information. Upon completion of those projects, the Ministry of Health signed an agreement in July 2009 with PHSA for the establishment of eHealth Operations to provide operational support services for eHealth applications.
- PHSA eHealth Operations provides operational support services for eHealth applications to the regional Health Authorities, the First Nations Health Authority and, in some cases, the Yukon (e.g., for Panorama).
- Operational support services (i.e., program management; system and user support; system enrolment and identity management; vendor contract management; and, privacy and/or security and data services) are provided for the following core components:

<u>Network Infrastructure</u>

- Private Physician Network (PPN) - provides physicians with a secure network to connect to their Electronic Medical Record (EMR) systems
- eHealth Network Gateway (eNG) - a secure network used by the health authorities

<u>Applications</u>

- Provincial Lab Information Solution (PLIS) - provides authorized clinicians with access to diagnostic laboratory test results via PHSA's CareConnect viewer
- Provincial Diagnostic Imaging Viewer (PDIV) - provides access to patient diagnostic images and reports via PHSA's CareConnect viewer
- Public Health Clinical and Surveillance Information System (Panorama) - provides authorized users with the ability to collect, share and analyze a wide range of public health information that is critical for addressing widespread disease outbreaks such as COVID-19, H1N1, SARS and other communicable diseases

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

The eHealth budget for 2020/21 is approximately $29.2 million. Prior year spending is identified in the table below:

| Fiscal Year | PHSA Actuals ($ Millions) |
|---|---|
| 2010/11 | 10.00 |
| 2011/12 | 13.61 |
| 2012/13 | 20.09 |
| 2013/14 | 22.23 |
| 2014/15 | 24.40 |
| 2015/16 | 26.08 |
| 2016/17 | 27.85 |
| 2017/18 | 32.91 |
| 2018/19 | 34.02 |
| 2019/20 | 31.54 |

**Approved:**

February 17, 2021 – Corrie Barclay, ADM, Health Sector IM/IT Division

February 24, 2021 –Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Laboratory Information Solution (PLIS)

### TOPIC

The Provincial Laboratory Information Solution (PLIS) is a repository of integrated laboratory information from both public and private labs, and includes lab test results from:

- all health authority (HA) laboratory systems;
- community labs through an interface provided by Excelleris – a division of Life Labs providing results-distribution services;
- the majority of HA specialty labs; and
- Canadian Blood Services.

### CURRENT SITUATION

- A Negotiated Request for Proposal to procure operational support services for the Health Information Access Layer – Provincial Laboratory Information System (HIAL-PLIS) was launched May 2018 and Maximus Canada Services Inc. (Maximus) was selected as the successful proponent.
- A Master Services Agreement (MSA) was executed between Maximus and the Province in February 2019. The MSA covers transition services, operations and incident management, application management, facilities management, asset and document management, reporting and annual operations planning services.
- The transition of HIAL-PLIS services from the previous service provider (Oracle BC) to Maximus was scheduled for completion by March 2020 but due to service provider delays, was subsequently targeted for the end of January 2021.
- Due to the required outage period of the system and impacts to accessing lab data for use in COVID-19 reporting and decision making, the Ministry of Health decided to defer and plan for the cutover for the Easter long weekend to help mitigate downtime impacts.
- The existing contract with Oracle BC was extended by 14 months to ensure continuity of services to May 31, 2021, with the ability to terminate with 60 days' notice should the transition be completed earlier.
- A separate Support Services Agreement was signed by the Province in April 2018 with Quest Diagnostics for the maintenance of the MedPlus and FCG software licenses being used by the PLIS system. The Quest five-year service term begins in June 2021.

### KEY FACTS

- Designated under provincial legislation (*eHealth Act*) and Ministerial Order as a Health Information Bank, PLIS:
    - enables the Ministry to better manage the utilization of laboratory services;
    - enhances clinical decision making when ordering and interpreting laboratory tests;
    - improves clinician access to higher quality information leading to better patient treatment and outcomes;
    - provides clinicians access to a single, complete source of patient laboratory information; and
    - reduces laboratory test duplication and system costs.
- PLIS now contains over 98% of all publicly funded laboratory results in British Columbia, including COVID-19 lab results.

<u>Access to PLIS Results through CareConnect</u>:

- Initial access to PLIS results through the Provincial eHealth Viewer, CareConnect[1], was limited to HA employees or those practitioners with HA privileges.
- In 2016, PLIS lab results were made available through Fraser Health Authority's Unified Clinical Information (UCI) network to authorized users within Fraser Health through their standard clinical interface.

[1] See also Legislative Session - Fact Sheet on CareConnect New User Onboarding

- In 2019, Vancouver Coastal Health project has enabled direct access for community physicians within the HA catchment to PLIS lab results through CareConnect.
- In FY 2020/21, the Provincial Health Services Authority (PHSA) begun a 3-year project to deploy CareConnect to the rest of the HA communities across BC.

## FINANCIAL IMPLICATIONS

- The legacy Oracle BC contract, set to expire in May 2021, has a monthly base fee of $1.3M.
- The MSA with Maximus commenced February 2019 with an initial term expiring February 28, 2025. The MSA had originally planned for 13 months of Transition-In Services and 60 months of Managed Operations Services (commencing upon completion of transition); however, transition required 24 months and as a result, only 49 months of Managed Operations services remain in the initial term.
- The Maximus MSA costs consist of:
    - Transition-In Services fee of $2.3M (one-time fixed price); and
    - Managed Operations Services fees of $50M for the initial term (monthly fee of $1.019M over 49 months or $12.23M per year).
- The Quest Support Services agreement base fee is $1.7M annually or $8.5M over the 5-year term of the agreement.
- The PHSA CareConnect project to enable HA communities to access PLIS will cost PHSA $4.2M and will be supplemented by the Ministry's contribution of $0.3M. In addition, after the 3-year project is completed, annual PHSA operating costs are estimated to be $1M.

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**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
April 6, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Prescription Management

### TOPIC

- Provincial Prescription Management (PPM) will permit the secure electronic creation and status management of community prescriptions by authorized prescribers and dispensers in the Provincial Drug Information System, PharmaNet, using clinical Point of Service solutions in a manner that integrates clinical workflow and software.
- PPM is a priority for the health sector and will enable the provincial viewing and management of community prescriptions across health care providers and care settings, minimizing care silos and supporting patient safety, practitioner efficiency and improved medication management.
- PPM provides a solution for electronic prescribing within a framework for comprehensive prescription management across a patient's care providers.

### CURRENT SITUATION

- The PPM project will implement Electronic Prescribing in BC, targeting early adopter Pharmacy Management System and Electronic Medical Record vendors in Q4 2020/21.
- BC is also working with Canada Health Infoway to assess the viability of the PrescribeIT service within BC's digital ecosystem and will continue to monitor the progress of other electronic prescribing services in other jurisdictions in Canada.

### KEY FACTS

- Electronic Prescribing was identified as a key action in HLTH's 2014 Setting Priorities for the BC Health System plan, its 2015/16 Service Plan, and its 2015 IM/IT Enabling Strategy.
- PPM will deliver Electronic Prescribing and is aligned to HLTH's Pharmaceutical, Laboratory and Blood Services Division's (PLBSD) priority actions 10 and 11 in response to the BC Coroners Service Death Review of the opioid crisis:
    - Priority Action 10: To ensure point of care access to PharmaNet medication information for all prescribers and dispensers of opioid medications and require prescribers and dispensers to check PharmaNet for at risk use.
    - Priority Action 11: To ensure access to PharmaNet medication information for all regulatory colleges of health care professionals prescribing and dispensing opioid medications.
- The health sector ranked PPM as one of its highest priority areas of focus, a key element of the recently endorsed Pharmaceutical Care Management Strategy for the Province. The goal is to improve patient safety and outcomes by leveraging the clinical value of PharmaNet, which incorporates prescribers and pharmacists into a single medication use platform with full prescription information sharing.
- PPM will:
    - Provide a digital recording of prescriptions within PharmaNet to allow viewing of patient prescription information province wide.
    - Improve prescription processes for prescribers and pharmacies, including assuring the authenticity (non-repudiation) of prescriptions.
    - Supports new strategies for virtual care and Primary Care Networks. Workflow options can be implemented to reduce or eliminate the need for patients to be physically present in physician offices or pharmacies, while maintaining the necessary safeguards for prescription management.
    - Improve patient access to medications and empowerment over choice of pharmacy. PPM will ease filling of refills at different pharmacies to accommodate patient location and preferences, or physical pharmacy related issues such as low medication stock or business closures.
- Health Authority Clinical Information Systems (CIS) are targeted for phase 2 leading to continuity of care for prescriptions during transition between community and acute care providers.

- Other benefits to which PPM contributes include:
  - Reduce prescription drug abuse: the use of prescription medication in a way not intended by the prescriber.
  - Reduce medication errors and adverse drug events by providing a Best Possible Medication History and alerting practitioners of adverse drug events documented in other care settings and reduce the harm resulting from medication errors, adverse drug reactions, allergic reactions and overdoses.

## FINANCIAL IMPLICATIONS

- The additional amount to complete PPM is estimated at $2.7 million.
- The technical pilot of PharmaNet ePrescribing, completed in 2013, cost $25.1 million.

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**Approved:**
January 29, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 17, 2021 - Corrie Barclay, ADM, Health Sector IMIT Division
April 6, 2021 – Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# FACT SHEET

# Securing Access to PharmaNet (PRIME)

## TOPIC

- The PharmaNet Revisions for Information Management Enhancements Application (PRIME) project was designed to allow the Ministry of Health (HLTH) to meet the requirements of the Information Management Regulation of the *Pharmaceutical Services Act*, which requires the Ministry of Health to be the sole approver of PharmaNet access.
- Current paper-based enrolment processes are frequently onerous for users and result in the Ministry having an incomplete view of PharmaNet use. In 2015, HLTH launched the PRIME project to develop an online application that enables eligible individuals to request access to PharmaNet, and which would allow the Ministry to monitor PharmaNet use by those individuals.
- PharmaNet is PharmaCare's business system that adjudicates claims for coverage and contains records of all dispensed drugs, devices, substances and related services from BC community pharmacies.

## CURRENT SITUATION

- PRIME is operational (as of December 1, 2020) and available for user enrolment for all health care practitioners except Device Providers.
- As per the Information Management Regulation (IMR), all *new* PharmaNet users must now request access directly from HLTH; most do this via PRIME.
- Site Registration is live for community practice sites; development is nearly complete to register community pharmacy sites, and in planning stages for health authority sites.
- Audit and monitoring tools are currently in development and planning stages.
- Roadmap for continued development into 2021/22 has been developed.

## KEY FACTS

Enrollment Solution Highlights (PRIME)

- PRIME uses the BC Services Card as a digital credential to securely identify and authenticate users.
- PRIME rolled out to new users (those without access as of November 30, 2020) of PharmaNet just before December 1, 2020. Grandfathered PharmaNet users will enroll in PRIME over a 16-month period as defined in upcoming changes to the IMR.
- Future releases of the PRIME application will:
    - Enable proactive access monitoring and user management, thereby reducing the number of information incidents related to inappropriate use and improving detection of and response time to information incidents.
    - Improve HLTH's ability to manage and control appropriate use of personal information.
    - Enable HLTH to apply unique user privileges and suspend/revoke access; and mitigate security issues identified in third-party assessments[1].
    - Reduce dependency on third party information sources tomonitor, audit, and investigate use of PharmaNet.
    - The identity management component of PRIME will support the success of several initiatives under the Digital Health Strategy, such as the sector IDAM (Identity and Access Management) strategy (e.g., for COVID vaccine administration) and other initiatives, such as electronic special authorities, electronic prescribing and electronic medication reconciliation.

PharmaNet Access Requirements

- Every prescription dispensed in community pharmacies in BC is entered into PharmaNet. Health care practitioners across the Province access PharmaNet to review patient history, support direct patient care and improve prescription safety.

[1] The most recent third-party assessment was a 2017 Deloitte evaluation of PharmaNet's user access management controls further to a series of PharmaNet breaches in 2016/17.

- HLTH is the owner of PharmaNet and, as such, is responsible for the implementation of appropriate information management policies and to ensure the protection of personal and private information stored in PharmaNet, including granting access to the system.
- PRIME ensures PharmaNet access conforms to the requirements of the Information Management Regulation ('IMR' – B.C. Reg. 74/2015) under the *Pharmaceutical Services Act*. The IMR supports adherence to industry best practices for user management, privacy and security.
- The IMR designates HLTH as the sole authority to approve PharmaNet access, and requires the policies and processes that the PRIME application provides to be in place for:
    - new users of PharmaNet to begin using PRIME to enroll by December 2020; and
    - all existing users of PharmaNet (as of November 30, 2020) to be re-enrolled using PRIME between December 2020 and April 2022.

## FINANCIAL IMPLICATIONS

- Capital spending, up to March 31, 2020, was $12.495 million.
- The 2020/21 capital budget allocation is $3.954 million.
- The 2021/22 notional capital budget allocation is $2.380 million.

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**Approved:**
February 17, 2021 - Corrie Barclay, ADM, Health Sector IM/IT Division
February 18, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## South Okanagan-Similkameen (SOS) Innovation Hub Initiative

### TOPIC

The Ministry of Health, TELUS Health, Interior Health Authority (IHA), Provincial Health Services Authority, and the South Okanagan-Similkameen (SOS) Primary Care Network have partnered to trial the development and launch of workable, affordable digital IM/IT solutions to enhance the delivery of and access to primary and community care.

### CURRENT SITUATION

- The SOS Innovation Hub Initiative was awarded the 2020 National Canadian Health Informatics Award for Innovation in Care Delivery.
- The project has delivered solutions to locally support:
  - Sending electronic referrals (successfully completed in January 2020)
  - Sending mental health assessments (successfully completed in September 2020)
  - A forms library to standardize requisition/referral forms and help users find forms using a filter (successfully completed in December 2020)
- Work is advancing for the completion of project activities described in the section below.

### KEY FACTS

SOS Innovation Hub Overview

- The following solutions are under implementation development:
  - A mechanism to improve system interoperability and support team-based care by enabling document files to be sent and received across separate systems by members of different clinical teams.
  - A merged electronic medical record (EMR) database that will allow providers from 9 community-based clinics to share patient records. If a patient of one clinic sees a provider in another clinic, their patient records will be immediately available, supporting the delivery of information, continuous care and ensuring that the "home" clinic is aware of any care decisions that are made.
  - A data warehouse solution to support advanced analytics and enable more in-depth and accurate resource planning based on population needs.
- Using these solutions, primary care providers in SOS will be able to share information electronically to better inform patient care, improve decision-making and reduce duplication of services.

Digital Health enabled vision for primary and community care

- The vision for primary and community care in BC involves improving the services British Columbians count on by delivering a quality, integrated and coordinated health care delivery system that:
  - is person-centred and effective in meeting population and patient needs;
  - delivers a quality service experience for patients in terms of access, appropriateness, acceptability, safety and efficiency; and
  - is easy to understand for those who use it and work in it.
- The Ministry recognizes the need for digitization to address the following challenges:
  - although many physicians in BC have adopted an EMR system, patients have little meaningful access to their health records;
  - doctors and health authorities often cannot share patient information directly through IT systems; and
  - interactions with the health system from a data perspective are fragmented due to providers holding their individual data within their own EMR systems, making it challenging to extract and share. This makes navigating patient records difficult for providers, and impossible for patients.
- The SOS Innovation Hub initiative supports the implementation of the Ministry's Primary Care Network initiative and aligns with the vision and goals of its Digital Health Strategy.
- The Ministry and the Provincial Health Services Authority plan to leverage certain assets and change management practices developed through the SOS Innovation Hub initiative to support provincial needs and solutions.

- Through the SOS Innovation Hub, we are working on community solutions that are first and foremost patient-centred.

## FINANCIAL IMPLICATIONS

The initiative is funded via two sources:

- The Strategic Investment Fund to support participation from TELUS (budget set at $3.9M with a $1M contingency - $4.9M total).
- Medical Service Plan expenditures to support participation from IHA and SOS Divisions of Family Practice were $301,244 and $651,965 for 2018/19 and 2019/20 respectively.
- The budget for Medical Service Plan expenditures for 2020/21 is $836,757 for IHA and SOS Divisions of Family Practice payments.

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**Approved:**
February 17, 2021 – Corrie Barclay, ADM, Health Sector IMIT Division
April 6, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporates Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Virtual Care Policy and Strategic Framework

### TOPIC

The COVID-19 pandemic resulted in a rapid and unprecedented system-wide adoption of virtual care in BC. In response, the Ministry of Health expedited several key provincial policies to ensure safe, effective care that aligns with strategic objectives. Virtual care has become a common means of health care provision, and will likely be still heavily integrated into our health care system beyond the COVID-19 pandemic. Because of this, key policy and guidelines on virtual care provision will continue to be essential, moving forward.

### CURRENT SITUATION

Virtual Care and COVID-19

- Pre-COVID-19, virtual care was not well integrated into the Canadian health care system[1]:
  - While 70% of Canadians would have taken the opportunity to have a virtual visit, only 4% of family physicians offered virtual care services[2]
  - Virtual care services accounted for roughly 2% of total fee-for-service payments to physicians in BC for the past several fiscal years[3].
- Since COVID-19, uptake of virtual care dramatically increased with approximately 84% of BC patients having connected with a physician virtually (phone, video, etc.) in the April to December 2020 period[4]. This uptake has been one of the most significant digital transformations that the Canadian health care sector has undergone. For example:
  - From April to December 2020, in-person office visits and consultations declined by 10.9 million (61%) relative to the same period in 2019.
  - At the same time, virtual care visits and consultations increased more than 12.2 million (3,315%) and more than offset the decline in similar in-person visits.[5]

### KEY FACTS

**Virtual Care Definition**

- Virtual care is the direct delivery of care between a patient and a provider, or communication between providers regarding the care of a patient, at distance, using information and communication technology. This includes, but is not limited to, video conferencing, telephone, text, and email. The care may be synchronous or asynchronous.
- The Digital Health Policy team at the Ministry of Health was tasked with developing the necessary standards, policies, and governance tools required to provide a provincial perspective on the future of virtual care in BC, and to support the Digital Health Strategy's modernization of the public health care system. Advice/Recommentation

Advice/Recommentations

[1] https://www.cma.ca/sites/default/files/pdf/virtual-care/cma-virtual-care-public-poll-june-2020-e.pdf
[2] https://www.cma.ca/sites/default/files/pdf/News/Virtual_Care_discussionpaper_v2EN.pdf
[3] Integrated Analytics: Primary Care, Acute Care and Workforce, April 26, 2021. Includes General Practice Services Committee and Specialist Services Committee payments.
Integrated Analytics: Primary Care, Acute Care and Workforce. April 26, 2021.. PAS# 3000.0772, MSP Claims data. .
[5] Ibid 1.

## FINANCIAL IMPLICATIONS

- Canada Health Infoway is providing $3.3 million to the Province, split between the Provincial Health Service Agency and the Ministry, to support the use of Virtual Care for COVID-19 and beyond.[6]
- Through a bilateral agreement with the Federal Government, the Province received approximately $18 million to further expand virtual health care services.[7]

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**Approved:**

February 17, 2021 – Corrie Barclay, ADM, Health Sector IMIT Division
April 23, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division
April 29, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

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[6] Canada Health Infoway "$3.3 Million in Funding will Support Virtual Health Care Across British Columbia During COVID-19 and Beyond." Published July 29, 2020 https://www.infoway-inforoute.ca/en/solutions/rapid-response-to-covid-19/5266-solutions/rapid-response-to-covid-19/8670-3-3-million-in-funding-will-support-virtual-health-care-across-british-columbia-during-covid-19-and-beyond

[7] "Government of Canada Invests $18 Million to Virtual Health Care Services in British Columbia." Published February 5, 2021. https://www.canada.ca/en/health-canada/news/2021/02/government-of-canada-invests-18-million-to-virtual-health-care-services-in-british-columbia.html

# LEGISLATIVE SESSION - FACT SHEET

# Workplace Evolving Services and Technologies (WEST) Contract Transition to NTT Data Canada Inc. (NTT)

## TOPIC

The current status of the NTT Data Canada Inc.'s provision of Workplace Evolving Services and Technologies (WEST) designed specifically to support BC health authorities' clinical environments and enhance productivity and end-user satisfaction.

## CURRENT SITUATION

- The Provincial Health Services Authority (PHSA), in close collaboration with the regional health authorities, continues to carefully monitor the transition project's progress and state of readiness of each line of services to be delivered under the WEST contract to ensure a positive user experience for frontline health care workers.
- Service issues were experienced during the late July 2020 transition, including longer-than-anticipated telephone wait times and problem resolution.
- PHSA and NTT have implemented mitigation plans to resolve the service issues, which included process optimization, increased training, and NTT hiring additional staff.
- Effort continues to be focused on achieving contractual performance levels.
- Based on a readiness assessment, a subset of services was deferred to occur after the July 2020 transition. Implementation of those deferred services continues to progress favourably. Five out of ten have been completed, and work continues to complete those that are outstanding.
- Plans are being developed and finalized that will ensure all expected outcomes of the contract are realized.
- Additionally, NTT has been working with the Province to support emergent COVID-19 requirements as it relates to contact tracing and other related initiatives.

## KEY FACTS

**Overview of Mitigation Plans**

Process-related

- Executive oversight has been provided by the PHSA Alliance Office and NTT in the development and management of recovery plans to stabilize NTT services.
- NTT has added specialized and experienced leaders to strengthen its service offerings, address any operational issues, and reach stabilization sooner. These new resources will ensure NTT team members are able to focus on providing essential and quality IT services to clinicians and business staff across the health authorities.
- The WEST contract is built on strong governance to ensure effective management and resolution of issues to meet clearly defined, measurable outcomes in the contract.

People-related

- Additional and enhanced training and staffing for the Service Desk, Clinical Service Desk, Deskside and all services areas have been implemented, as well as leveraging and further developing knowledge with the health authorities across all service areas.
- Utilizing Article 34 of the Collective Bargaining Agreement and with support from the BCGEU, NTT was able to engage temporary, non-union Canadian resources to assist with post-Assumption-of-Service stabilization efforts.
- Additional resources have been onboarded in various service lines to stabilize services, e.g., clinical and technical service desks and Deskside.
- Focus continues to be placed on maturing process and knowledge management inputs to improve user experience and service outcomes.

# LEGISLATIVE SESSION - FACT SHEET

**Contract Highlights**

- With government's approval, the PHSA, in its capacity as agent for the BC health authorities, signed a contract with NTT DATA Canada Inc. for the provision of WEST on March 18, 2019. This contract replaced the previous IBM Desktop Management Services (IBM) contract that had been in place since 2010.
- NTT is a global company with more than 40 years' experience delivering workplace and device technologies and services in clinical environments, including for thousands of hospitals and long-term care facilities.
- Under the new contract, NTT provides services and tools specifically designed to support clinical environments, enhance productivity and enhance user satisfaction.
- Transition from IBM, including a transfer of BCGEU and non-contract staff, occurred on July 29, 2020.
- One of the most significant benefits of the new service contract is that health authorities now have access to both a clinical and non-clinical service desk, as well as multiple ways to access It support, including via calls, live chat, a self-service portal, email and voice mail.
- This PHSA/NTT relationship is a first for BC's health system. Following Vested® principles and methodologies, it emphasizes a collaborative relationship between NTT and the health authorities, where all parties are vested in each other's success rather than just being a transactional relationship. This new alliance focuses on shared values and goals, joint outcomes, and continuous improvement.

**Privacy Breach Allegations against NTT – August 2020**

- In August 2020, the Official Opposition raised concerns in the BC Legislature respecting allegations that NTT had sent files and provided access to British Columbians' personal health information to individuals located outside of Canada, i.e., in the United States and India, during the transition of help desk services from IBM Desktop Management Services to NTT.
- These allegations were investigated and found to be without substance.
- During the transition of help desk services, NTT temporarily engaged 22 US-based resources on a project basis to assist in triaging and assigning backlogged Service Desk tickets.
- These short-term, US-based agents, in place from July 31 to August 7, had no access to British Columbians' personal health information, and no medical or personal files were transferred to other countries.
- Compliance with BC and Canadian privacy policies and regulations has also been confirmed.

## FINANCIAL IMPLICATIONS

- The WEST deal, as negotiated, includes substantial initial cost savings and projected year-over-year unit cost reductions. The contract value is $403 million[1] for the initial five-year term of the contract.
- Fiscal impacts to the Province will be neutral as health authorities will fund contract costs through their existing budgets.

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**Approved:**

February 17, 2021 – Corrie Barclay, ADM, Health Sector IMIT Division

February 21, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] Cited per Provincial Services Health Authority, May 8, 2019

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# LEGISLATIVE SESSION - FACT SHEET

## Advisory Committee on Diagnostic Facilities

### TOPIC

- The Advisory Committee on Diagnostic Facilities (ACDF) is a sub-committee of the Medical Services Commission (MSC), with delegated authority to assess and approve, or recommend denial of, applications for new, expanded, or relocated outpatient diagnostic facilities or to transfer material financial interest.
- Such approval is required for a facility to bill the Medical Services Plan (MSP) for provision of outpatient diagnostic services.

### CURRENT SITUATION

- Pursuant to Section 6 of the *Medicare Protection Act*, the MSC has formally established the ACDF as a "panel", consisting of:
    - Three government members
    - From one to three public/beneficiary members (at least one of whom is not a practitioner)
    - Three physician members
- Government and public/beneficiary representative members are nominated by the Assistant Deputy Minister having responsibility for outpatient diagnostic services within the mandate of the ACDF. Physician members are nominated by the Doctors of BC's Board of Directors.

### KEY FACTS

- The MSC has delegated authority to the ACDF to assess applications from outpatient diagnostic facilities for certain restricted services, including:
    - diagnostic radiology
    - diagnostic ultrasound
    - nuclear medicine scanning
    - polysomnography
    - pulmonary function
    - electromyography (EMG)
    - electroencephalography (EEG)
- Based on MSC-approved policy, the ACDF may approve a facility application, as well as attach, add, delete, or amend conditions to the approval as necessary or advisable.
- The ACDF cannot deny an application, but can recommend denial to the MSC, which provides final adjudication.
- Accreditation by the College of Physicians and Surgeons of BC's Diagnostic Accreditation Program is a condition of every ACDF approval.
- The ACDF meets four times a year to assess applications.
- The ACDF assesses applications in accordance with the Medical and Health Care Regulation, which requires that:
    - there is sufficient medical need for the service;
    - the quality of the proposed diagnostic services is sufficiently high;
    - there is reasonable utilization of existing approved diagnostic facilities, which provide the same services for which approval is sought and which are located within the catchment area under consideration; and
    - the principal(s) of the facility applying for the approval does not have a real or potential conflict of interest (approval may be granted in exceptional circumstances where a potential conflict of interest exists, but the services could not reasonably be provided by another diagnostic facility).

# LEGISLATIVE SESSION - FACT SHEET

- In fiscal 2019/20 the ACDF assessed 69 applications, resulting in 66 approvals and 3 recommendations for denial, all of which were upheld by the MSC. 27 applications were from publicly-owned and 42 applications were from privately-owned facilities.
- Full operational and administrative support for the ACDF is provided by a Secretariat from the Beneficiary and Diagnostic Services Branch of the Ministry of Health.
- The Secretariat is also responsible for ongoing policy development, both for the workings of the ACDF itself and for modality-specific facility approval policy. Recent examples include:
    - A review of outpatient ultrasound policy, which resulted in select privately-owned facilities being approved to bill MSP for non-cardiac Doppler studies and changes to provincial outpatient distance-reading (telemetry) policy.
    - Deregulation of referred electrocardiography services.
    - A review of pulmonary function testing resulting in changes to community-based spirometry facility approval policy with the intent to reduce wait times and improve access for the diagnosis of Chronic Obstructive Pulmonary Disease.
    - Improvements to the MSP Claims Billing System that provide the capability to identify whether diagnostic facilities are complying with conditions of approval and to ensure billings are appropriate.
    - A detailed review of the service delivery environment for diagnostic sleep testing in BC, resulting in the initiation of formal accreditation for Home Sleep Apnea Testing facilities through the College of Physicians and Surgeons of BC's Diagnostic Accreditation Program and a mandate to develop two new sleep medicine guidelines and a provincial standardized sleep medicine requisition through the MSC's Guidelines and Protocols Advisory Committee; documents aimed at assisting referring practitioners in making consistent, appropriate referrals for diagnostic sleep testing.

## FINANCIAL IMPLICATIONS

- Non-government members of the ACDF are remunerated for time involved with preparation and participation in quarterly meetings and are reimbursed for expenses related to attending one annual in-person meeting (three of four meetings are by teleconference; one is in-person).
- Payment is based on MSC established rates for general and specialist physicians (public members are paid at general physician rate, unless they happen to be a specialist physician).

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**Approved:**
February 11, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services

# LEGISLATIVE SESSION - FACT SHEET

## Agency Nurses

### TOPIC

Health authority usage of temporary agency services to address health system nursing workforce demands.

### CURRENT SITUATION

- Health authorities utilize services of contracted agencies to address episodic and ongoing nursing vacancies in hospital; and community and long-term care (LTC) sectors. This is especially evident in rural and remote communities in BC.

Advice/Recommentations

Advice/Recommentations

Additionally, HEABC is currently working with the Provincial Health Services Authority (PHSA) to align recent system updates to data reporting standards; as such, PHSA is excluded from this analysis.[3]

### KEY FACTS

- Through the Provincial Health Workforce Planning Process, 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 personnel are registered with the appropriate BC Colleges, undertake an employment check prior to contract, are oriented to the health authority worksite and are required to abide by all health authority policies, procedures and work direction.
- Currently HEABC tracks the number of hours/proportion of non-regular vs regular hours and year over year trends by health authorities including agency nursing utilization, along with provincial averages (for registered nurses and licensed practical nurses); however, no costing data is collected. RN data include Community Health Nurses (CH), General Duty Nurses (DC), and Programs and Services Nurses (PS). Nurse managers are excluded.[4]
- Pay rates for agency nurses are generally higher than the standard scale for hospitals or care facilities. Agencies also charge an administration fee to the health employer in addition to the nurse's wage. The 2019-2022 Nurses' Bargaining Association (NBA) contract outlines a number of parameters around the use of contracted nursing services, including:
    - Acute Care and Community Nursing: For the purposes of this agreement no nurse will be involuntarily laid off due to contracting out or due to shifting healthcare resources from acute care to communities or long-term care.[5]
    - Long Term Care Nursing: Health authorities (HAs) and Providence Health Care (PHC) will not layoff nurses employed in long term care as a result of any contracting out. Regardless of the review conducted by the Ministry of Health, if a nurse is voluntarily laid off by a contracted service provider due to contracting out the HA will guarantee that the nurse will have no loss of salary, employment, benefits, service and seniority.[6]
    - Casual Employees: If a casual employee is terminated due to contracting out, by an affiliate member who has contracted to provide services to a HA/PHC, the HA/PHC will make all reasonable efforts to add that casual employee to a casual list in a comparable nursing position within the HA/PHC provided

[1] HEABC. January 18, 2021. Page 7. *Strategic Nurse Staffing Committee (SNSC) Regularization Report*.

Advice/Recommentations

[3] HEABC. January 18, 2021. *Strategic Nurse Staffing Committee (SNSC) Regularization Report*.

[4] Ibid

[5] *2019 – 2022 Nurses' Bargaining Association Provincial Collective Agreement Summary of Changes December 2018*. Retrieved from:http://heabc.bc.ca/public/CAs/NBA/SummaryofChanges_NoInterps.pdf, p. 96, accessed September 30, 2019.

[6] Ibid.

the casual employee has demonstrated they have the requisite qualifications prior to the placement on the list.[7]

Health Authority Agency Nurse Utilization

- Agency nurse utilization is highest for Northern Health, comprising 10.17% of non-regular hours (compared to 0.78% for Interior Health, the lowest utilization).[8]
- 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 was unable to fill with internal applicants.[9]
- The supply of nursing in the North has not changed over the past two years; however, demand has increased by 13% over this same time period (this increases to 16% when positions created for the COVID-19 response are included). This can be attributed in part to the increase in primary care services and regularization of hours throughout the North.[10]
- Both Interior Health and Fraser Health have indicated that they do not have an increased need for agency nurses. [11]
- First Nations Health Authority has seen an increased need for agency nurses and have required to draw upon several agencies to address needs.[12]
- Vancouver Coastal Health indicated they have explored use of agency nurses to support home health services; however, were not successful in securing agency resources.

Northern Health Health Human Resource Strategy

- In 2018, The Office of the Auditor General of BC released the findings of their independent audit and recommendations for recruitment and retention of rural and remote nurses in northern BC.
- Northern Health has advised the majority of the recommendations have been either fully or partially implemented, including the development of a health human resource strategy with a multi-faceted approach to nursing workforce planning, recruitment and retention. The response to the recommendations has included an investment of $1.1 million by government to launch the first nursing degree program in the North East to be delivered by UNBC in Fort St John, in partnership with Northern Lights College and Northern Health. Beginning September 2021, the program will admit 16 students (with scale up in subsequent years to 32 students at full capacity (Refer to: *OAG Independent Audit of the Recruitment and Retention of Rural and Remote Nurses in Northern BC Fact Sheet*).
- The strategy and related approaches to addressing HHR issues, will help to enable the successful recruitment and retention of nurses in rural and remote areas, thereby minimizing the reliance on the contracted services of agency nurses in the North in the medium to long term future.

Safety Issues and Use of Agency Nurses

There are limited studies available on the association between use of temporary agency nurses and adverse patient and nurse outcomes. One U.S. study investigated the association between use of temporary nurses and nurse needlesticks and back injuries, in addition to patient falls and medication errors. The study results showed that high levels of use of temporary RN nursing staff (i.e., 15% or more temporary RN hours) were associated with high levels of back injuries and patient falls. As such, the study suggests that health care institutions **maintain the level of temporary nurse usage below 15% of RN hours to ensure both nurse and patient safety.**

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

January 26, 2021— Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 1, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

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[7] Ibid, p. 97
[8] HEABC. January 18, 2021. Page 8. *Strategic Nurse Staffing Committee (SNSC) Regularization Report*.
[9] Ibid.
[10] Rossi, Sandra-Lee, Northern Health. Personal email communciations. January 22, 2021.
[11] Maclaren, Joanne. Senior Director, Nursing Policy Secretariat, Health Sector Workforce and Beneficiary Services. Personal email communications. December 8, 2020.
[12] Ibid.

# LEGISLATIVE SESSION - FACT SHEET

## Alternative Payments Program

### 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 the fee-for-service payment modality would be ineffective in attracting and maintaining adequate physician services.

### CURRENT SITUATION

- Under the APP, funding is provided to health authorities and other agencies to contract physician services through service contracts, salary agreements, and sessional arrangements (3.5 hour blocks of time) in adherence with requirements set out in the Physician Master Agreement (PMA) and Ministry policy.[1]
- Examples of clinical programs funded by APP are emergency rooms, oncology, psychiatry, pediatrics and primary care.[2] For clarity, physician agreements associated with recently announced primary care initiatives such as Urgent and Primary Care Center, New to Practice Family Physician, and Practicing Family Physician contracts as well as new Anesthesia contracts are not included under APP.

### KEY FACTS

- In the 2020/21 budget, APP funds 1,180 Full-time Equivalents in 173 contract commitments[3] and 158,516 sessions[3,4] for physician services. The distribution of funding across APP funding modalities is: 85% contract (for service contracts and salaries) and 15% sessions[3]. Of the 12,941 physicians in BC who received payment for patient care in 2019/20, 4,337 physicians received all or part of their income through APP funding.[5]
- APP funding has proven to be effective in stabilizing public access to primary care physician services in many rural and remote communities where the fee-for-service payment mechanism would be considered inadequate due to small populations or financially too risky for physicians to commit to establish practices in those communities.
- APP funding has also proven to be effective in attracting and retaining highly skilled specialists to enable BC to build provincial centres of excellence such as: BC Cancer Agency, BC Children's Hospital and BC Transplant.
- The Ministry communicates APP funding allocations by way of Funding Letters to health authorities and annual funding commitment letters to other agencies to assist them with their planning. Within this overall commitment, the Ministry then enters into service specific APP funding agreements with health authorities and other agencies to further specify service objectives that are aligned with the Government's strategic health care objectives and/or to strengthen value for money.
- Within the commitments of APP funding provided by the Ministry, health authorities and other agencies then enter into contract, sessional or salaried compensation arrangements for physician services that have been agreed to with the Ministry. Health authorities and other agencies must ensure that the arrangements they enter into with physicians are compliant with the Physician Master Agreement negotiated between the Government and the Doctors of BC for compensation of physician services, as well as comply with Ministry and Government policies and directives applicable to APP funding.
- For service verification, evaluation and audit purposes, health authorities and other agencies have a responsibility to transmit details of the services to the Ministry of Health the same as required for physicians billing fee-for-service.[6]

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[1] 2019 Physician Master Agreement https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/consolidated-pma-2019.pdf

[2] Alternative Payments Program Policy Framework – updated January 2014, Chapter 1 Section 5 page 2 of 2. Retrieved on 2017-06-27 from http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/app_policy_framework.pdf

[3] Based on the 2020/21 APP Budget Book. Calculations:Security Concern

Security Concern

[4] Numbers change when funding is shifted from one payment modality to another.

[5] Primary & Acute Care and Sector Workforce; Health Sector Information Analysis & Reporting Division. Ministry of Health. 2021. MSP. Data as of January 28, 2021.

[6] Reference: Physician Master Agreement - Alternative Payment Program – Individual Template Service Contact, Article 14 – Reporting; Group Template Service Contract, Article 15 – Reporting; Individual Template Sessional Contract, Article 13 – Reporting; Group Template Sessional Contract, Article 14 – Reporting

- Compliance with this reporting requirement has been problematic, particularly with physician services provided on a sessional basis (e.g., mental health and addictions; palliative care; geriatric care) and with some contracted specialist services (e.g., BC Cancer Agency; BC Children's Hospital). The Ministry is working with health authorities and other agencies and collaborating with the Medical Services Commission to address these problems.
- **APP Transformation Initiative:** Improvement with respect to administration of the APP is well underway. The vision of the APP Transformation Initiative is to provide enhanced flexibility and accountability of funding used to purchase physician services through operational excellence in the physician services funding processes. The transformation is currently focused on accountability in the form of complete data reporting and standardization in order to support evidence-based decision making and analytics. Future improvements will focus on accountability with regard to process/policy compliance and funding flexibility. Phase One of a health authority integrated APP system was completed and rolled out to health authorities at the end of June 2020. Development for Phase Two is underway and is focused on enhancing the database to support contracts associated with primary care and surgical renewal strategic initiatives.

## FINANCIAL IMPLICATIONS

- Fiscal year 2019/20 expenditures were $559.91 million.
- The 2020/21 budget is $614.58 million. The APP contract and sessional budgets are as follows ($ = millions)[3]:

| Health Authority | Contract | Sessions | Total |
|---|---|---|---|
| FHA | $ 40.24 | $ 17.20 | **$ 57.44** |
| Interior | 31.75 | 3.43 | **35.18** |
| NHA | 23.20 | 5.88 | **29.08** |
| PHSA | 178.47 | 14.28 | **192.75** |
| VCH & Providence | 100.08 | 35.87 | **135.95** |
| Island Health | 48.76 | 11.02 | **59.78** |
| Other Agencies * | 7.15 | 4.16 | **11.31** |
| Other Funding ** | 93.09 | - | **93.09** |
| **TOTAL** | **522.74** | **91.84** | **614.58** |

* Other Agencies includes Nisga'a Valley Health Authority, University of BC, Ministry of Children & Family Development, and Community Living BC Commitments.

** Other Funding represents budget reserved for grid disputes, additional contract-related commitments, third party recoveries, and PMA commitments that have not yet been allocated to Health Authorities or Agencies.

- The APP budget represents approximately 11.7% of the Medical Services Plan sub-sub vote.

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**Approved:**
January 25, 2021 – Mark Armitage, ADM, Health Sector Workforce & Beneficiary Services Division
February 1, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 7, 2021 – Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## 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) 2019-2022 Collective Agreement.

### CURRENT SITUATION

The APADBA and HEABC reached a tentative agreement on July 19, 2019; the agreement was fully ratified on September 30, 2019 under the 2019 Sustainable Services Negotiating Mandate.

### KEY FACTS

- The APADBA Collective Agreement covers 5,257 employees or 3,544 Full Time Equivalents (FTEs) and represents total annual compensation (including wages and benefits) of $442.8 million.[1]
- Primary Care Paramedics make up 71% of active employees.[2]
- The average annual compensation for an ambulance sector FTE is approximately $98,576 (including the cost of wages, benefits, and non-employee specific costs), or $46.46 per hour. [3]
- Paramedics and ambulance dispatchers work for BC Emergency Health Services (BCEHS), which is part of the Provincial Health Services Authority. The Canadian Union of Public Employees (CUPE) Local 873 represents employees in the ambulance subsector.

Creation of Standalone Bargaining Association for Paramedics and Dispatchers

- In 2010, BCEHS CUPE Local 873 and BCGEU employees were transferred from the Ministry of Health to the Facilities Bargaining Association (FBA) to better integrate ambulance services with the broader health care system in BC.
- A standalone bargaining association, the Ambulance Paramedics and Ambulance Dispatchers Bargaining Association, was established on January 18, 2018.
- Until the new agreement was ratified for the APADBA, the ambulance subsector agreement existed as an appendix to the FBA collective agreement.
- Administrative and support staff at BCEHS who are represented by British Columbia Government and Service Employees Union remain in the FBA.

2019 Bargaining Round (Sustainable Services Negotiating Mandate)

- Bargaining between APADBA and HEABC under the Sustainable Services Negotiating mandate began in January 2019, the tentative agreement was reached July 19, 2019, and the first standalone APADBA collective agreement was ratified on September 30, 2019.
- Highlights of the agreement include:
    - 3-year term (April 1, 2019 to March 31, 2022);
    - General wage increases of 2% annually;
    - Language to support the transformation of the ambulance service model with new, permanent paramedic jobs in smaller communities; and
    - Changes that support service delivery improvements.

COVID-19 Pandemic and the Kilo Shift Guarantee Phase-Out

- In the current collective agreement, APADBA and BCEHS agreed to a new deployment model that will improve 24-hour emergency response coverage and the recruitment and retention of Paramedics in up to 92 rural and remote communities throughout BC.

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[1] PSEC Public Sector Compensation Annual Forecast 2021 (unreleased) pg. 35

[2] HEABC Fact Sheet Ambulance Subsector, retrieved October 1, 2019 from: http://www.heabc.bc.ca/public/Bargaining/2019/FactSheets/FactSheetAPAD-2018.pdf

[3] Ibid.

- The new scheduled on call (SOC) model will offer regular part-time employment to paramedics who will be required to carry a pager and respond to emergency calls following their regularly scheduled hours of work.
- Due to the COVID-19 pandemic, the implementation of the SOC model, with agreement between the BCEHS and APADBA, was put on hold while all BCEHS resources were focused on the priority of supporting staff and patient care.
- BCEHS identified 39 higher call volume stations not appropriate for SOC and the phase out of Kilo Guarantee was scheduled for April 3, 2020. Due to COVID and the temporary suspension of collective agreement implementation, the Kilo Guarantee was extended for April and May 2020.
- For 39 BCEHS urban and rural stations with higher call volumes, the Kilo Guarantee will not be continuing, and shifts scheduled on June 1, 2020 onwards will revert to the Kilo call-out language in the collective agreement.
- 92 rural and remote BCEHS stations with lower call volumes and are SOC candidate stations will continue to receive the Kilo Guarantee until they transition to the new staffing model or, if SOC is yet to be implemented will cease receiving Kilo Guarantee November 1, 2021.
- Implementation of the new scheduled on call deployment model commenced in Spring 2021.

## FINANCIAL IMPLICATIONS

The APADBA collective agreement represents approximately $442.8 million in annual expenditure on compensation.[4]

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**Approved:**
June 10, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[4] PSEC Public Sector Compensation Annual Forecast 2021 (unreleased) pg. 35

# LEGISLATIVE SESSION - FACT SHEET

## Anesthesia Assistants in BC

### TOPIC

- Anesthesia Assistants (AAs) are specially trained health professionals who provide care throughout the anesthesia continuum under the supervision of an anesthesiologist.
- AAs are typically respiratory therapists (RTs) or registered nurses (RNs) who have pursued a defined period of didactic and clinical training specific to the competencies required to be an AA.[1] The majority of AAs in BC have an RT background.
- In 2019, there were 87.65 AA FTEs (headcount of 118) in BC. This represents a 14% increase compared to 2018.[2]
- The need for AAs is growing due to a shortage of anesthesiologists in Canada and BC, increasing surgical procedures due to the surgical renewal strategy, extension of operating room (OR) hours, and a growing number of procedures requiring anesthesia support outside of the OR.

### CURRENT SITUATION

- AAs are not currently regulated under the *Health Professions Act* (HPA). RNs are regulated in BC under the HPA; RTs will be regulated under a new Regulatory College of Allied Health and Care Professionals, as per the province's regulatory framework modernization.[3]
- The Canadian Society of Respiratory Therapists (CSRT) is the national professional association that: developed and validated a *National Competency Framework in Anesthesia Assistance* (NCF AA*)* in 2016; is the corporate entity under which post-diploma AA programs are accredited; and administers a national certification exam for AAs (annually).[4] Students who have graduated from an accredited program can write the national certification exam to be designated as a Certified Clinical AA (CCAA). Although successful completion of the exam is not currently mandatory for practice in BC, many health authorities (HAs) strongly prefer to employ those with CCAA certification.
- Currently BC has 2 training programs: Thompson Rivers University (TRU); and an in-house program at Vancouver General Hospital (VGH).
- TRU's AA post-diploma program is an Open Learning self-paced format: the didactic portion is online and followed by a 16-week clinical practicum in the hospital environment.
    - Students are expected to complete this program in less than 2 years (maximum is 3 years) and arrange for their own clinical placements with an anesthesiologist.
    - TRU's program is available to applicants across Canada. It is designed for RTs or RNs to continue working while completing AA training.
    - Graduate numbers per year fluctuate due to ongoing enrollment and flexible timelines for completion. On average, TRU graduates 7-9 BC students annually.
- VGH's in-house AA training program, started in 2017, was created to support a predictable supply of graduates and a desire for a formalized cohort-based education model with clinical educator coordination and support. The program is currently only offered to Vancouver Coastal Health employees. It consists of 2 months didactic, 6 months practicum, and 3 months orientation. There are 3-4 graduates annually, and graduation is timed with the national certification exam sitting.
- Both the TRU and VGH programs are accredited with conditions by the CSRT. [5]
- In 2018, St. Paul's Hospital (SPH) ran a 9-month cohort-based pilot program in collaboration with TRU, which was supported by AEST through a one-time funding grant. Funding supported the salary for an on-site clinical coordinator/educator. The goal of this pilot was to develop a framework for a high quality, well supported

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[1] Canadian Anesthesiologists' Society. (2020). Appendix 5: Position paper on anesthesia assistants: An official position paper of the Canadian Anesthesiologists' Society. Retrieved January 29, 2020 from https://www.cas.ca/CASAssets/Documents/Practice-Resources/Guidelines/12630_2019_1507_MOESM4_ESM_Appendix-5.pdf

[2] HEABC 2018-19 Health Human Resources Data– September 9, 2020. Includes affiliate data.

[3] See PRO fact sheet: Regulation of Diagnostic and Therapeutic Health Professions for more information.

[4] Canadian Society of Respiratory Therapists. (2017). Accreditation services manual: anesthesia assistant/anesthesia clinical assistant education programs. Retrieved January 29, 2020 from https://www.csrt.com/accreditation/

[5] ibid

clinical education model that could be replicated and used for AA training provincially. All 4 students successfully completed the program in March 2019 and passed the national exam.

- In 2019, the Ministry of Health examined required competencies for AAs practicing in BC; factors affecting preparedness of AA students entering clinical placements; and HA and anesthesiologist expectations of the profession. A report (Meadows, 2019) was completed with 5 recommendations for strengthening and standardizing AA entry to practice competencies and meeting HA requirements for this profession.[6]

## KEY FACTS

- The Ministry, in collaboration with HAs, AEST, and TRU, is leading a working group to support implementation of the report recommendations (Meadows, 2019). Currently, the working group is focused on provincially standardizing entry to practice and competency requirements that align to the NCF AA. This work is expected to be completed in Spring 2021.
- In March 2020, AEST secured year-end funding to support TRU to run another cohort-based program that would result in 20 graduates by the end of December 2021. Based at two sites in the Lower Mainland, a cohort of 10 students (5 at each site) began in September 2020. The second cohort began in January 2021, however only 7 seats were filled. Challenges included limited ability for employees outside the lower mainland to participate (program would require employees to live in the lower mainland for the 7 month clinical placement portion of the training), as well as HA funding barriers for sponsoring students and securing net new positions for graduates.

Cabinet Confidences

- The Ministry is currently working towards identifying anticipated provincial AA supply needs, and will be collaborating with AEST and stakeholders from HAs and TRU to determine a suitable education model that will meet HA needs.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[6] See Supplemental document: AA Project Report (Meadows-2019) Summary
[7] See Supplemental document: BC regulatory framework modernization and AAs for more information

# LEGISLATIVE SESSION - FACT SHEET

# Anesthesia Care Team (ACT)

## TOPIC

Anesthesia Care Teams (ACT) are interprofessional teams of health care professionals such as anesthesiologists, anesthesia assistants, nurses and family practice anesthetists who work together in an integrated manner with persons, families and caregivers in the provision of anesthesia care.

## CURRENT SITUATION

- To support the increase in surgical capacity due to the COVID-10 pandemic, the Ministry of Health is implementing ACT models of care to help build system capacity to address ongoing patient surgical needs.
- The Ministry's Nursing Policy Secretariat, in collaboration with the Allied Health Policy Secretariat, Physicians Services Branch and the Professional Regulation Branch, is leading the implementation of ACT models of care throughout the province.
- The Ministry is currently engaging with health system partners to prepare for ACT implementation.

## KEY FACTS

- In May 2020, through the *B.C. Surgical Renewal Commitment* plan, the Ministry committed to significantly increase the number of surgeries performed beyond pre-COVID-19 levels to catch up with the lost cases as a result of COVID-19 impacts and to keep up with the ongoing demand over the long term.

Government Financial Information

- The ACT model aligns with the Plan's goal to increase surgical personnel, including looking at alternative models such as ACTs and nurses providing anesthesia services to address service gaps.
- The model also aligns with the Ministry 2020/21 Service Plan objective to ensure team-based service models are in place to support health human resources needs of the *B.C. Surgical and Diagnostic Imaging Strategy*.
- The results of evidence review/ jurisdictional scans conducted by the Ministry highlighted the following key benefits of an ACT model of care: improved access to surgical services and a reduction in surgical wait times for priority surgeries; improved patient safety; and increased cost-effectiveness of care.
- The ACT model promotes a quality working environment by enabling providers to work to their optimal professional scope of practice and improving consistency and quality of supports available for providers.
- Implementation of an ACT model of care is intended to achieve the goals of the Quadruple Aim, i.e., optimize health system performance through improving population health; enhancing the experience of care for individuals (and experience of care delivery for providers); and reducing per capital cost of health care.

ACT Framework

- An ACT Framework has been developed to articulate a vision of how ACT models can function in BC and how healthcare professionals in ACTs can apply team-based approaches to deliver anesthesia services to patients. The Framework also provides a foundational structure for outlining how ACT roles can work together throughout various phases along the patient journey through the anesthesia care process.
- The Framework demonstrates the governance approach in developing a collaborative and strategic implementation plan with partners to optimize ACTs across the province. It also provides the platform for partner organizations to map out their patient care needs, surgical service delivery, and ACT roles according to scope of practice and expertise ensuring the right care at the right time for the right patient.
- The Framework does not focus on one standard model: the framework will enable implementation of various types of ACT models and team composition based on demonstrated community need; capacity of facility to deliver / provide support for various tiers of services; and available providers to provide supervision, ongoing support to ACT members and ability to ensure continued competency.

Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

Under Development

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**Approved:**

April 23, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Anesthesia Compensation Strategy

### TOPIC

Overview of Anesthesia Strategy to recruit and retain more anesthesiologists in BC and stabilize and improve surgical throughputs by offering a new compensation model and increased rates above the existing fee-for-service (FFS) compensation model.

### CURRENT SITUATION

- Negotiations continue to introduce the Provincial Template at more sites, with active negotiations or physician interest ongoing.
- Surgical Renewal Anesthesia Funding has taken place for 14 sites across BC with more sites to follow if required. This funding represents the commitment to increase capacity in order to address the backlog within the next 17-24 months as part of BC's Surgical Renewal Plan.
- There is also a separate but parallel strategy to the Group Contract Model for anesthesiologists who opt to remain on FFS. The 2019 Physician Master Agreement increased FFS compensation, with proportionately higher increases to anesthesiologists and other physicians who tend to work after hours (17% increase to the after-hour fees).

### KEY FACTS

Background

- There were 574 anesthesiologists practicing in BC[1] in fiscal year 2019/20.
- The majority are paid on a FFS basis. 2019/20 Medical Service Plan FFS expenditure on anesthesiology was $148.9M[1]. Total Ministry expenditure on anesthesiology was $197.8M[2]
- Anesthesiologists provide perioperative (from admission to discharge) care to patients.
- A key role of anesthesiologists is to support both elective and emergency surgical services.
- Anesthesiologists also provide important services out of the operating room, for example chronic pain management services, pre-surgical screening, and labour epidurals.
- Stabilizing and expanding anesthesia services is a key component of Government's broader strategy to reduce surgical wait-times.
- Anesthesiologists have been recognized as a recruitment and retention priority in Government's Health Human Resources strategy. BC has an undersupply of anesthesiologists, a challenge which is widespread and is more serious in some regions.
- There has been a history of challenging negotiations with anesthesiologists. While this area is complex, some of these challenges have related to the level of compensation and degree of individual provider accountability and autonomy.

Group Contract Model

- In 2018, Leadership Council approved the introduction of a Group Contract Model (non-FFS), a new compensation model for anesthesia services.
- The Group Contract Model represents a meaningful financial investment by Government in anesthesia, as it offers higher hourly rate compensation as compared to current FFS compensation.
- Key objectives of Group Contract Model:
    - Strengthen provincial supply to enhance surgical capacity - by offering a nationally competitive compensation package. (balance this with fiscal responsibility).
    - Stabilize services/increase the group accountability of anesthesiologists – by ensuring departments have sufficient anesthesia resources to respond to increasing service needs; and providing financial incentives to increase after-hour services.

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[1] B.C. Ministry of Health, Health Sector Information, Analysis & Reporting Division. Anesthesiologists are counted if they received payment for direct patient care. February 2021. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/irm_complete.pdf

[2] Total expenditure includes fee-for-service, Alternate Payment Program, Specialist Services Committee, Medical On-Call Availability Program and Rural Incentives. Payments from Health Authority global operating budgets are excluded.

  - Expand services/define process for expansion - to aid growth planning of surgical services.
- Key characteristics of Group Contract Model:
  - Hourly pay, with after-hours premiums and surgical performance targets
  - Agreed schedule, with minimum coverage requirements
  - Joint physician/health authority process to recruit anesthesiologists
- Provincial Template:
  - To implement the Group Contract Model, the Government and physician representatives (the Doctors of BC and the BC Anesthesiology Society) negotiated a Provincial Template Group Service Contract (the "Provincial Template") in fall of 2018. The Provincial Template provides the basis for local negotiations in which each group of anesthesiologists (by site) are able to consider and/or voluntarily sign on to a Group Service Contract.
  - Sites currently signed on to the Provincial Template include St. Paul's Hospital and Mount Saint Joseph's Hospital (Vancouver), Royal Inland Hospital (Kamloops), Mills Memorial Hospital (Terrace), Cariboo Memorial Hospital (Williams Lake), Royal Columbian Hospital (New Westminster),Eagle Ridge Hospital (Port Moody), Vancouver General Hospital and UBC (Vancouver), Penticton Regional Hospital (Penticton), East Kootenay Regional Hospital (Cranbrook) and Kootenay Boundary Regional Hospital (Trail)Three private facilities have signed on to the provincial template False Creek Health Care Centre, ASC Vancouver Surgical Centre, Seafield Surgical Centre (Nanaimo) and Comox Valley Hospital (Comox) with more sites in negotiations
  - Too early for full evaluation, but recruitment and surgical cancelation rates have improved in the months following introduction of Group Contract Model.

## FINANCIAL IMPLICATIONS

- The cost of the Group Contract Model is partially offset by reduced costs in other programs such as FFS, Medical On-Call / Availability Program, and the Alternative Payments Program.
- Fiscal Year 2019/20 Group Contract Model expenditures were $21 million.
- Fiscal Year 2020/21 Group Contract Model expenditures were $79.4 million.
- Actual costs incurred under these contracts will be paid out when final expenditure data is provided, including costs incurred for approved expansion requests and schedule modifications.

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**Approved:**

June 4, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Planning & Reporting Division
June 7, 2021 –Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division
June 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Anesthesia Recruitment

### TOPIC

To support anesthesia services and meet surgical capacity targets, the Ministry of Health is engaged in multiple activities to alleviate human resource pressures around anesthesiology.

### CURRENT SITUATION

- Health authorities have anticipated the following workforce gaps at the end of 2020/21[1]:
  - 536 active anesthesiologists and a gap of 37 anesthesiologists.
  - 74 active family practice anesthesiologists (FP-As) and a gap of 9 FP-As.
- All health authorities have highlighted the limited supply of anesthesiologists and FP-As as a significant risk to meeting surgical capacity targets in BC.
- The Ministry is collaborating with health authorities and the Health Employers Association of BC (HEABC) to actively address workforce challenges.

**Recruitment Strategies**

- Health Match BC (HMBC) has been provided $815,000 to provide additional recruitment support for anesthesia, surgical nurses, and select allied health professions.
- In June 2020, HMBC launched a renewed anesthesiology recruitment campaign. Actions to date have included:
  - A virtual exhibit at the Canadian Anesthesiologist Society virtual event in June 2020.
  - New custom recruitment materials targeting BC-trained anesthesiologists currently practicing outside of the Province to promote local opportunities and encourage them to practice closer to home.
  - Direct candidate outreach to international medical graduates, final year residents, new US registrants.
  - HMBC virtual career fair, held in November 2020.
- Focused recruitment efforts have yielded results:
  - From April 1, 2020 to February 4, 2021, focused recruitment efforts resulted in 54 anesthesiologists and 4 FP-As hired across the province[2]

**Education and Training**

Postgraduate Medical Education (PGME or residency training)

- The University of BC (UBC) is a key contributor to BC's physician supply; residents play a critical role to help increase healthcare delivery capacity by providing direct patient services while they train.
- In 2020/21, 62 anesthesia residents were training/providing care across years 1-5 of the program.
- UBC historically offered 10 entry-level anesthesiology residency positions. Recognizing the demand for more anesthesiology services, the Ministry provided additional funding to expand as follows:

| Year | # entry-level positions | | Year | # entry-level positions |
|---|---|---|---|---|
| 2018 | 11 | | 2020 | 14 |
| 2019 | 13 | | 2021 | Government Financial |

- UBC also administers a 1-year FP-A Enhanced Skills program for family physicians interested in developing anesthesia skills to meet community needs in rural and remote settings.
  - The FP-A program increased from 1 to 3 positions in 2016/17 and offered 4 positions in July 2020.
  - The Ministry is working with UBC to further increase FP-A to 5 positions in 2021.

Anesthesia Assistants

- The Ministry is working with the Ministry of Advanced Education and Skills Training (AEST), health authorities and Thompson Rivers University to offer 2 fast-track anesthesia assistant cohorts.
- The first cohort of 10 will complete the program in August 2021, and the second in December 2021.

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[1] Period data self-reported by health authorities to the Health Workforce Planning and Implementation Branch (projections updated monthly).
[2] Ministry of Health. A Commitment to Surgical Renewal in B.C. Progress Report #9 January – February 2021. March 19, 2021. https://news.gov.bc.ca/files/surgical-renewal-commitment-progress-report-9-Jan_Feb2021.pdf

BC Clinical Anesthesiology Fellowship Program

- The BC Clinical Anesthesiology Fellowship Program is the first of its kind and represents an innovative approach to training as well as recruitment and retention.
    - In collaboration with UBC Faculty of Medicine, College of Physicians and Surgeons of BC, and regional health authorities, the Ministry is offering up to six 12-month anesthesiology fellowships for US-trained physicians who successfully completed a 4-year anesthesiology residency recognized by the Royal College of Physicians and Surgeons of Canada.
    - Each candidate must demonstrate successful completion of US licensing examinations and be Board Certified/Board Eligible in Anesthesiology to be considered for the fellowship.
- Intake for these fellowship positions will be in July 2021 and will include a 2-year return of service in a Ministry and health authority-identified community of need.
- Fellows are eligible to write the Royal College certification exam in Anesthesiology upon successful completion of the fellowship program.

Government Financial Information

**Anesthesiology Contract**

The Ministry, health authorities and the Health Employers Association of BC are working to increase uptake of the provincial anesthesia contract.

- As of January 22, 2021 there were a total of eight sites across the province that have anesthesia contracts in place, with further sites in negotiation.
- See *Anesthesia Compensation Strategy Fact Sheet* for further information.

## KEY FACTS

Anesthesiologists are specialist physicians responsible for patients before, during, and after surgical operations, labour and delivery, and certain interventional procedures.[3]

- Anesthesiologists monitor and control a patient's vital life functions, pain, and level of consciousness during surgical procedures.[4]
- Anesthesiologists also support, and in appropriate circumstances, lead, the provision of resuscitation, critical care medicine, palliative care, and pain medicine.[5]
- Family practice anesthetists (FP-As) also provide anesthesia services primarily in rural and remote communities in BC.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

June 2, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

June 7, 2021 – Kristy Anderson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division

[3] Royal College of Physicians and Surgeons (2017). Anesthesiology Competencies. https://www.royalcollege.ca/rcsite/documents/ibd/anesthesiology-competencies-e . Last accessed January 26, 2021.

[4] BC Anesthesiologists Society (2020). https://bcanesthesiologists.ca/about-british-columbia-anesthesiologists-society/ . Last accessed January 26, 2021.

[5] Royal College of Physicians and Surgeons (2017). Anesthesiology Competencies. https://www.royalcollege.ca/rcsite/documents/ibd/anesthesiology-competencies-e . Last accessed January 26, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Associate Physicians

### TOPIC

Introduction of a new "associate physician (AP)" class of registration under the bylaws of the College of Physicians and Surgeons of BC (CPSBC) for internationally educated physicians (also referred to as International Medical Graduates or IMGs) who are not eligible for a full or provisional license.

### CURRENT SITUATION

AP Class of Registration

- The CPSBC engaged with key stakeholders, health Authorities (HAs), Doctors of BC, University of BC and Ministry of Health, in 2019 regarding these bylaw amendments. Through consultation, the CPSBC was made aware of the need for a restricted class of practitioners in acute care settings to increase capacity and service delivery.
- On April 2, 2020, CPSBC provided notice of proposed bylaw amendments intending to create a new restricted "associate physician" class of registration. The bylaw was posted for a two-week public comment period. CPSBC received a significant volume of feedback both in support of, and opposition to, the proposed bylaw amendments.
- To qualify for registration in the restricted AP class, candidates must have[1]:
  - a medical degree;
  - successfully completed Part 1 of the Medical Council of Canada Qualifying Examination;
  - at least two years of postgraduate training in a medical or surgical specialty;
  - health authority sponsorship; and
  - Canadian citizenship, be a permanent resident or legally able to live and work in BC.
- The AP role is not intended to be an entry or alternative pathway to provisional or full licensure but, instead, a restricted class of medical practitioner functioning within structured team-based specialty care settings to increase capacity and service delivery. An AP may not be the most responsible provider and must practice under the direction and supervision of an attending physician.[2]
- The AP role is comparable, to varying degrees, to the 'Clinical Assistant' role in Alberta, Manitoba, and Nova Scotia. Typical job duties often include documenting patient history, conducting a complete physical examination, developing a treatment plan and writing appropriate orders in consultation with the attending/supervising physician. If working in a surgical unit, provision of pre-and-post-operative care as well as intra-operative assistance.[3]
- Effective May 29, 2020, the CPSBC's bylaws were brought into force.
- To fully integrate APs into the system, an implementation strategy was developed in collaboration with HAs, Health Match BC (HMBC) and Health Employers Association of BC (HEABC).

AP Implementation Strategy

- Establishing APs in BC requires considerable planning with health system partners to ensure appropriate and safe integration into HAs. The Ministry has worked in partnership with CPSBC, HEABC and HAs to develop the policies, processes, and structures needed to support successful implementation.
- CPSBC has prepared registration policies and accreditation standards to exercise greater regulatory oversight over APs as a result of feedback received from practitioners in BC in response to its draft bylaws.
  - The three registration policies encompass: a) use of title b) eligible clinical programs and c) registration and licensure requirements for eligibility and accountability.
  - The accreditation standards for employing APs encompass: a) initial accreditation and b) ongoing accreditation. Each unique program area within a HA requires separate accreditation by CPSBC in accordance with the accreditation standards.

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[1] CPSBC. Bylaws (June 1, 2009, revised January 8, 2021). Associate Physician 2-24. https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf. Last accessed January 18, 2021.

[2] CPSBC. Bylaws (June 1, 2009, revised January 8, 2021). Associate Physician 2-24. https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf. Last accessed January 18, 2021.

[3] Alberta Health Services. Clinical Assistants. https://albertahealthservices.ca/medstaff/Page7094.aspx. Last accessed January 18, 2021.

- In collaboration with HEABC, a compensation framework was developed and approved by the Public Sector Employers' Council in September 2020. A salary agreement has been developed by HEABC in consultation with HAs.
- Stakeholder engagement meetings have been held with: Provincial Medical Services Executive Council; Doctors of BC via the Physician Services Committee; Resident Doctors of BC; and Nurses and Nurse Practitioners of BC.
- Candidate screening and recruitment processes have been developed in collaboration with CPSBC, HMBC and HEABC. HMBC will be providing a pre-screening and referral service once open positions in accredited AP programs are posted. HMBC has actively engaged with candidates who have expressed interest in future AP opportunities.
- Targeting full enablement by February 2021 with hiring and onboarding of APs in Spring 2021.

## KEY FACTS

- IMGs are individuals who have obtained their medical education from medical schools (listed in the World Directory of Medical Schools) outside of Canada and the United States. IMGs have a broad range of experience from years of practice to no patient experience at all.
- 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.
- The CPSBC is the provincial regulatory body which has been delegated the authority to ensure physicians are qualified, competent and fit to practise medicine in BC in the interest of patient safety. The CPSBC is responsible for setting the licensing criteria for physicians in BC.
- The national regulatory bodies, the College of Family Physicians of Canada and Royal College of Physicians and Surgeons of Canada (RCPSC), oversee the medical education of family physicians and specialists respectively in Canada. They are responsible for setting the specialty-specific training requirements for certification.
- For IMGs who have completed specialty training (i.e. internal medicine) 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.
- For IMGs who do not meet the requirements set out by the RCPSC and do not wish to redo postgraduate medical education (PGME or residency), the AP class of registration presents a limited pathway to practise medicine in BC for IMGs with the appropriate qualifications.
- For IMGs with family medicine training who are licensed, practicing physicians in other countries that do not meet the requirements set out by the CFPC, the Practice Ready Assessment-BC (PRA-BC) program provides an alternative pathway to licensure in BC. (See also 'Pathways to Practice for Internationally Educated Physicians' and 'PRA-BC' Fact Sheets).

## FINANCIAL IMPLICATIONS

N/A – APs will be HA employees. As such, the decision to hire an AP to address health human resource needs will be determined by HAs.

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**Approved:**
January 31, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## BC Loan Forgiveness Program

### ISSUE

The 2015 change in criteria used for the BC Loan Forgiveness Program (LFP) underserved community designation and eligibility has presented challenges for recruiting and retaining health care professionals, most predominantly nurses, to rural communities in BC.

### CURRENT SITUATION

- Provincial health authorities continue to indicate that the LFP is an important incentive tool to recruit and retain health care professionals to underserved communities in BC.
- The Ministry is working with the Ministry of Advanced Education and Skills Training (AEST) to ensure health system priorities and objectives for recruitment and retention of select health care related occupations to underserved communities in BC are clear and can help inform any future LFP policy and/or design through 2021/22.

### KEY FACTS

- The LFP is administered by AEST through StudentAid BC. It was established in 2002 and provides a financial incentive for select health-related occupations through loan forgiveness for eligible participants working in an underserved community in BC.
- The LFP will forgive the outstanding BC portion of Canada-BC integrated student loan debt at a rate of up to 20% per year for up to 5 years.
- Recipients must provide 400+ hours per year of in-person service at a publicly funded facility in an eligible occupation working with children or in an underserved community to receive the maximum reimbursement.
- The Province will also pay any outstanding interest that accumulates during each year the participant is registered in the program.
- The Ministry of Health works closely with AEST in the selection of both the health care occupations and communities eligible for the program.
- The list of underserved communities is currently derived from the Rural Practice Subsidiary Agreement (RSA) between the BC Government, the Doctors of BC, and the Medical Services Commission. The list targets remote communities in BC where access to physician services is limited and includes a rating system that assigns isolation points to BC communities resulting in a list of rural communities designated in four classes (A, B, C or D).
- The Ministry identifies a list of priority professions for the health sector and develops strategies on the education, recruitment, retention, deployment and optimization of the workforce.
- Subject to program funding and capacity, AEST utilizes this list to determine health related occupations eligible for LFP.
- Health professions currently eligible under LFP include:
    - Physicians (including Residents);
    - Nurses (including LPNs, RNs, RPNs, NPs, and Specialty RNs);
    - Midwives;
    - Audiologists;
    - Speech Language Pathologists;
    - Medical Laboratory Technicians;
    - Diagnostic Medical Sonographers;
    - Physiotherapists;
    - Occupational Therapists;
    - Respiratory Therapists;
    - Polysomnographers.

- Nurses have the highest uptake of LFP, receiving over $848K in loan forgiveness grants in fiscal 2020/21, accounting for approximately 53% of all payments made under the program that year.[1]

LFP Review History

- AEST conducted a review of the LFP in 2014 to examine user demand, financial pressures and program delivery in order to address program budget constraints and utilize program resources more efficiently.
- As one of the outcomes of this review, AEST redefined underserved communities eligible under LFP as those in RSA classes A and B only to more effectively target funding.
    - As a result, a number of communities in RSA classes C and D such as Sechelt, Hope, Port Alberni, and Salt Spring Island, are no longer considered eligible under the program.
    - Health authorities and several rural communities continue to express concern to both the Ministry and AEST in regard to recruiting and retaining health care professionals, (predominantly nurses) to their respective communities.
- In 2019 AEST conducted an internal review of all StudentAid BC programs, including LFP, and the existing policy framework was seen to be effective in ensuring budget resources were being directed to areas of highest need; and,
- Any subsequent program model revisions or eligible occupation additions would require consultation with partner ministries and careful budget considerations.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
May 27, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[1] Ministry of Advanced Education, Skills and Training, email from Roger He, Lead, Budgets, Finance & Accounting – StudentAid BC, May 18, 2021

# LEGISLATIVE SESSION - FACT SHEET

## Bill 47 – Health Sector Statutes Repeal Act

### TOPIC

Bill 47 (*Health Sector Statutes Repeal Act*) was brought into force through regulation on July 1, 2019. Bill 47 repealed two existing pieces of legislation, the *Health and Social Services Delivery Improvement Act* (Bill 29) and the *Health Sector Partnerships Agreement* Act (Bill 94), which facilitated contracting out in the health sector and caused significant labour impacts.

### CURRENT SITUATION

- Contracted food and housekeeping services previously performed by Facilities Bargaining Association (FBA) members are being assessed for repatriation back into health authority operations.
- Due to COVID-19, repatriation of services has been delayed, and short-term extensions have been negotiated for contracts which expired during the pandemic. Discussion on upcoming expiries are underway.
- Remaining contracted services will be assessed for repatriation at a later date.

### KEY FACTS

- Bill 29 provided public health sector employers the right to contract out non-clinical services and voided certain provisions (e.g. successorship conditions) in existing health sector collective agreements.
- Bill 94 was intended to facilitate development and implementation of public-private partnerships in the health sector and provided flexibility in contracting out and restructuring for private operators
- Both Bill 29 and Bill 94 contributed to job loss in the health and community services sectors and were seen to have negatively impacted continuity of care, particularly in long term care.
- Bill 47 received royal assent on November 27, 2018 and came into force through regulation on July 1, 2019.

Health Sector Consultations and Summary Report

- In early 2019, a cross-government working group consulted with 20 stakeholder groups including regional health authorities, the Provincial Health Services Authority, Providence Health Care, major health sector unions, patients, and frontline health sector workers.
- Through the consultations, stakeholders identified opportunities and challenges Bill 47 may present, and these were compiled into a summary report, which examined the feasibility of repatriating certain service lines.

Bill 47 Working Group

- The 2019-2022 FBA collective agreement contains a memorandum of agreement mandating the establishment of a Bill 47 working group within 30 days of Bill 47 coming into force. The working group first convened on July 26, 2019.
- The working group includes members of the Health Employers Association of BC, the Hospital Employees' Union, health authorities, Business Initiatives and Support Services and the Ministry of Health.
- The working group is tasked with developing guidelines and processes to identify opportunities, assess feasibility and support repatriation of contracted services, if government gives direction to return a service into the public sector.

Activities Underway

Advice/Recommentations; Government Financial Information

- The Ministry continues to provide support to the Bill 47 working group, including monitoring ongoing requests for proposals to be issued by health authorities and providing direction on contracts which are approaching expiration.
- The working group developed guidelines and principles for the possibility of repatriating various services lines. This included a labour adjustment template agreement to facilitate an orderly transfer of services from a contracted employer to the health authority.

- number of contracts for patient food, housekeeping and security are set to expire in 2021, 1 year extensions with 6 month early termination clauses are being negotiated for contracts expiring in early 2021.

## FINANCIAL IMPLICATIONS

- The public health sector workforce in BC represents approximately $15.3 billion in annual compensation[1].

Government Financial Information

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**Approved:**

January 25, 2021 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] PSEC Public Sector Compensation Annual Forecast 2019 (unreleased) pg. 33
[2] PHSA/BISS updated financial information

# LEGISLATIVE SESSION - FACT SHEET

## Cambie Surgeries Corporation Legal Action

### TOPIC

In January 2009, in order to prevent the Medical Services Commission (MSC) from conducting an audit to detect evidence of systematic violation of the *Medicare Protection Act* (MPA), Cambie et al commenced legal proceedings against the Minister of Health, the MSC, and the Attorney General of BC alleging that sections of the MPA that prohibit extra billing and private insurance for Medical Services Plan (MSP) benefits are in breach of the *Canadian Charter of Rights and Freedoms*.

### CURRENT SITUATION

- On September 10, 2020, the BC Supreme Court ruled in the Government's favour; all sections of the MPA being challenged in this litigation were upheld.
- The Plaintiffs have filed an appeal. The appeal is expected to be heard in June 2021.
- On December 8, 2020 a judge of the Court of Appeal issued a limited form of injunction which prohibits the MSC from exercising its powers of enforcement under sections 21(2) and (3), 45.1 and 46(5.1) and (5.2) of the MPA in respect of any private surgeries where a patient has been scheduled for a date beyond 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 is in effect until June 18, 2021 or further order of the Court.

### KEY FACTS

- In March 2008, the MSC ordered an audit of Cambie Surgeries Corp. (Cambie) and the Specialist Referral Clinic (Vancouver) Inc. (SRC) after having received numerous complaints the clinics were charging patients for insured benefits in violation of sections 17 and 18 of the MPA.
- In January 2009, an action was filed in the BC Supreme Court by the Canadian Independent Medical Clinics Association and 5 private clinics, including Cambie, asserting that the prohibitions on extra billing and private insurance in the MPA constitute a deprivation of rights guaranteed by sections 7 and 15 of the *Charter.*
- When the MSC completed its audit of Cambie and SRC, it found the 2 clinics were charging patients for, or in relation to, services that are MSP benefits.

<u>Plaintiffs, Trial Motions and Trial Date</u>

- The audit report was released on July 18, 2012. The MSC filed an interim injunction application against both Cambie and SRC in early September 2012. The MSC also requested its Audit and Inspection Committee undertake audits of the physicians who appeared to have been involved in overlapping billing, where both patients and MSP were billed for, or in connection with, the same medical service.
- In October and November 2012, the plaintiffs filed 25 affidavits sworn by various patients and physicians, in response to the MSC injunction application. The MSC applied to strike out large parts of the affidavit material, and the plaintiffs applied to prohibit the MSC from bringing its interim injunction application.
- On February 27, 2013, the MSC instructed its legal counsel to agree to put the interim injunction application into abeyance, to permit the parties to focus on getting to trial on both the constitutional issues and the permanent injunction application in an expeditious way.
- The Cambie trial was at various times scheduled to start on: January 5, 2014, September 8, 2014, March 2, 2015 and June 6, 2016 but was deferred in each instance.
- On March 18, 2016, in response to a revised Notice of Constitutional Question being served upon them by the Plaintiffs, the Attorney General of Canada joined the litigation as a party pursuant to the *Constitutional Question Act*.
- Over the summer of 2016, the counterclaims of the Minister of Health, the MSC and the Attorney General of BC were discontinued. In exchange, the plaintiffs discontinued their claims against all defendants other than the Attorney General. A new counterclaim was filed on behalf of the Attorney General.
- The trial began on September 6, 2016. On April 10, 2017, after completing approximately one third to one half of the Plaintiffs' case, the trial was adjourned. During the adjournment, the parties were expected to work together to facilitate the presentation of the evidence and reduce the number of witnesses, objections

to evidence, and time required by each witness in Court.

- The resumption of the trial was adjourned several times but resumed on April 9, 2018.
- In April 2018, the Government amended the MPA effective October 1, 2018 to bring sections of the MPA into force that were approved by the Legislative Assembly in 2003 (Bill 92) but were not brought into force at that time. Bringing these sections of the Act into force enhances the authority of the MSC and introduces penalties for non-compliance which will ensure that eligible BC residents (beneficiaries) receive quality public health care based on need, not on ability to pay. These changes uphold the fundamental principles of the MPA as well as the *Canada Health Act*.
- In November of 2018, following an application by the plaintiffs, the Court issued an injunction preventing the enforcement of the prohibitions on extra billing until June 1, 2019. An application for leave to appeal the injunction was dismissed on January 24, 2019.
- The parties entered into a Consent Order in September of 2019 that continues a very limited form of injunction (preventing use of most of the Bill 92 enforcement provisions against private surgical clinics) until the decision on the constitutional challenge was issued on September 10, 2020.
- After written arguments by all parties (and the intervenors) were exchanged, final argument took place over three weeks beginning on November 18, 2019. The final argument was interrupted by the trial judge's sudden unavailability after two weeks, and finally concluded on February 28, 2020.
- On September 10, 2020, the BC Supreme Court ruled in the Government's favour; all sections of the MPA being challenged in this litigation were upheld.
- On December 8, 2020 a judge of the Court of Appeal issued a limited form of injunction which prohibits the MSC from exercising its powers of enforcement under sections 21(2) and (3), 45.1 and 46(5.1) and (5.2) of the MPA in respect of any private surgeries where a patient has been scheduled for a date beyond 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 is in effect until June 18, 2021 or further order of the Court.

## FINANCIAL IMPLICATIONS

- In March 2020, BC Ministry of Finance received communication from Health Canada stating the final Canada Health Transfer payment in March 2020 would be reduced by approximately $16.5 million based on reported extra billing. However, this communication also explained that a $16 million reimbursement was being provided, reflecting a 50% reimbursement of deductions made from the March 2018 and March 2019 Canada Health Transfer payments.
- With the September 2020 ruling now received, BC has notified the Federal government of the intention to continue extra billing enforcement (within the parameters of the December 2020 injunction) and audits with the expectation that the Province will receive funds previously withheld by the Federal Government.

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**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Cayton Report – Inquiry into the College of Dental Surgeons of BC

## TOPIC

- In March 2018, the Honourable Adrian Dix, Minister of Health launched an inquiry into the College of Dental Surgeons of BC (CDSBC) under section 18.1 of the *Health Professions Act* (HPA) due to concerns about the governance and operations of the college.
- On April 11, 2019, the Minister released a report developed by Harry Cayton of the UK Professional Standards Authority entitled: *An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (the Cayton report).

## CURRENT SITUATION

- The Cayton report identified 21 recommendations and 11 unmet standards of good regulation.

Advice/Recommentations

## KEY FACTS

- The Cayton report concluded that CDSBC meets 17 of 28 standards of good regulation (60 %), and provided 21 recommendations for CDSBC.
- The Cayton report also provided evidence of significant, ongoing dysfunction with the Board, while noting some improvements, at that time, in the Board's focus on the public interest.
- The Minister accepted all of the recommendations and on April 9, 2019, under section 18.2 of the HPA, issued a directive to CDSBC instructing it to submit an implementation plan within 30 days (May 13, 2019) detailing the measures it will take to implement the recommendations and the unmet standards of good regulation.
- On May 13, 2019, CDSBC submitted their response entitled: *Action Plan: Addressing the Recommendations and Unmet Standards in the Cayton Report* (the Action Plan).
- In a letter of July 15, 2019, the Minister informed CDSBC's board that he was "encouraged by the commitments to change set out in the Action Plan, but [was] concerned about the pace of action and the critical substantive changes needed for the functioning of the board, its relationship with staff, and independence of the board from the BC Dental Association (BCDA)."
- The Minister's July 15, 2019, letter requested changes in the following areas:
    - CDSBC board size and composition - Requested bylaw changes, including to reduce board size.
    - Eligibility for election and board membership - Requested bylaw changes, including to prohibit officers or directors of dental associations from serving on the CDSBC board. Requested CDSBC board members complete CDSBC's declaration of conflict form and the Ministry be advised on how any real or perceived conflicts will be addressed.
    - Collection of dental association fees - Requested bylaw changes to remove CDSBC from collecting fees on behalf of the BCDA or another similar organization. Requested CDSBC provide a plan on how the separation will occur.
    - Relationship between board and staff - Requested CDSBC provide a staff and board development plan.
- On September 16, 2019, the amended CDSBC bylaws, which were filed with the Ministry of Health, came into force. Bylaw changes included addressing committee structure and composition to remove the requirement for a board member to be on the Inquiry Committee.
- A smaller CDSBC board was announced on September 19, 2019 and Carl Roy was subsequently elected as chair.
- On July 28, 2020, further bylaw amendments dealing with the CDSBC board, committees and panels came into force. These changes included creating a new Standards and Guidance Committee mandated to develop, maintain and review standards of practice and professional ethics, and creating a new Patient Relations Committee.

- In July 2020, CDSBC released its Action Plan Progress report, dated June 2020, to show the college's progress on the Action Plan.

Advice/Recommentations

| *Summary of Cayton Report Recommendations to the CDSBC* |
|---|
| **Governance, Conduct and Probity**<br>• The board should continue with its plans to reduce its size, to increase the representation of public members and to appoint officers from within its membership.<br>• No one who has held an officer position in the British Columbia Dental Association or any other representative organization for dentists should be allowed to stand for election until at least three years after they held office.<br>• No dentist under investigation for a complaint should stand for election or be appointed to a committee until the complaint has been resolved in their favour.<br>• Any dentist on a board or committee who is under investigation for a complaint should step down until the complaint has been resolved.<br>• The board should review its committee structure with the aim of reducing the number of committees making the college's decision-making more streamlined and effective.<br>• Board officers, the registrar and college staff should be more diligent in monitoring progress on workstreams and recording the implementation of decisions.<br>• The college should create a risk register to be maintained by senior staff and monitored by the audit committee. Results will be reported to the board.<br>• The board should continue to increase transparency and be ready to be held accountable to the public.<br>• The college should renew its commitment to proper procurement policies and should conduct legal contracts through its general counsel.<br>• The board must mend its relationship with its professional staff. |
| **Performance of the College**<br>• The college should significantly improve its internal data collection and performance management.<br>• The college must sort and organize its documents. Standards should be gathered together in a single document and titled accordingly.<br>• The board should remove itself from the complaints process and should not attempt to influence or interfere in complaints in any way. |
| **External Relationships**<br>• As part of its new strategic plan, the college should develop a stakeholder mapping and communications strategy.<br>• The college should work to improve the reach and response rate of its annual complaints survey.<br>• The college should open part of its board meeting to questions and comments from the public.<br>• The college should aim to build a relationship of both mutual respect and distance with its dentist registrants.<br>• The college should commit more time, respect and interest to certified dental assistants and dental therapists.<br>• The college should encourage better and more regular engagement with the three other dental colleges to promote the safety of patients and public protection.<br>• The college should be clearer about the collection and distribution of fees.<br>• The college should resolve to stop collecting fees for the BC Dental Association in a phased manner. The suggested transition time is no more than three years for the two organizations to separate. |

## FINANCIAL IMPLICATIONS

The expenses incurred by the government for an inquiry respecting a health profession college are a debt due and owing by CDSBC to the government. The inquiry cost less than $225,000 and this debt was paid by the CDSBC in 2019.

**Approved:**

June 1, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 3, 2021 – Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Changes to First Responder Examination and Licensing Process

### TOPIC

The Board is shifting how Emergency Medical Assistant (EMA) First Responders (FR)s are licensed to align with the licensing requirements of all other EMAs. This shift will remove the historical role that employers play in licensing in order for the Board to have a more appropriate and direct relationship with licensees.

### CURRENT SITUATION

- The Emergency Medical Assistants Licensing Board (Board) is authorized under the *Emergency Health Services Act* to protect the public through the examination, registration, and licensing of Emergency Medical Assistants (EMAs) in BC while setting terms and conditions for a licence and investigating complaints about EMAs. The EMA Licensing Branch (Branch) supports the Board and is part of the Health Sector Workforce and Beneficiary Services Division in the Ministry of Health.
- In 1987 arbitrator Stephen Kelleher ordered the reinstatement of a paramedic whose licence had been revoked by the Emergency Health Services Commission and identified the conflict in EHSC's role as the employer and the licensing body. Further to this the *Health Emergency Act* was amended in 1989 to ensure that the licensing body for emergency medical assistants was separate from the employer. This amendment removed the role of the employer having authority over the licensing of EMAs in BC.
- The EMA FR program however is run such that the employer has a role in the applicants' licensing decision *and*, a licence is not issued without the employer's approval. This practice is in contravention of the Board's purpose and is unfair to licence applicants.
- Since the Branch does not receive proof of program completion or completed examinations, there is no definitive confirmation that either requirement has taken place. The Board may be putting itself and public safety at risk by continuing this process of licensure for EMA FR applicants.
- The current process of licensure also creates confusion for the EMA FR licensee because the licensing relationship is with the employer rather than with the Board and Branch. This results in a lack of understanding by EMA FRs regarding their statutory obligations as a licensed EMA in BC. This is evident in the number of scope of practice violations and code of ethics infraction complaints received by the Board.
- The Board and Branch are moving toward ensuring that the licensure process for all EMAs is fair and consistently applied. In recognition that these are substantial changes to the first responder process, the changes will be implemented in a staged approach throughout 2021/22 with the intention of full licensure alignment by January 1, 2022.

<u>Current Process</u>

- EMA FR completes a Board recognized EMA FR program (EMALB does not receive verification; only the employer and training provider receive this information).
- EMA FR completes the written exam and two practical scenarios (EMALB does not receive proof of completion; only the employer has access to this information).
- The employer submits the course results form that includes the applicant's names.
- EMALB receives the application for licence from, which is often completed by the employer rather than the applicant, inconsistent with other licence category applicants.
- The applicant completes a Criminal Record Check.

<u>New Process[1]</u>

- The applicant submits a request for an evaluation form.
- Employer/training provider submits proof of successful completion of a Board recognized EMA FR program.
- The applicant successfully completes the EMALB online written examination.
- The applicant successfully completes the online jurisprudence examination.
- The applicant successfully completes the practical examinations invigilated by the Branch examiners.

[1] Fully implemented by EMALB by January 1, 2022

- The applicant applies for a licence.
- The applicant completes a Criminal Record Check.

## KEY FACTS

- January 1, 2019 - An online EMA FR written examination was implemented for EMA FR licence renewal.
- April 7, 2020 - The Board approved updates to the licence reinstatement policy aligning the requirements for EMA FR licence reinstatement with all other licence categories.
- May 29, 2020 - The EMA Licensing Branch announced staged changes to the first responder initial licensing process with the intension of aligning with all other licence category requirements by April 1, 2021. Those changes included:
    - August 1, 2020 - All initial first responder applicants arerequired to submit a certificate of successful completion of training to be eligible for licensure (these are generally submitted by the training institutions and fire departments).
    - September 1, 2020 - All EMA FR initial licensing written exams will be moved to the online format currently being used for EMA FR licence renewals
    - April 1, 2021 - All EMA FRs will be required to complete the online jurisprudence examination for initial licensing and licence renewals.
    - April 1, 2021 - Practical examinations for EMA FRs will be aligned with the practical examinations for all other licence categories, and training institutions will no longer be permitted to invigilate practical examinations.
- June 1, 2020 - Training institutions and fire departments were included in a consultation period regarding how best to move forward with the alignment of practical examinations. The consultation period runs from June 1, 2020 to September 30, 2020, at which time the Board and Branch will review the feedback and make a plan that works for all departments and the Branch.
- December 2020 - The EMA Licensing Board Chair, Ryan Sinden, has created a working group based on the feedback received from the consulation.
- April 15, 2021 - Formulation of delivery options is currently underway in coordination with the working group and implementation of the new process has been postponed until January 1, 2022.

## FINANCIAL IMPLICATIONS

- EMAs are responsible for the cost of Criminal record checks.
- Providing EMALB practical examinations will likely double the current need for examinations resulting in a possible requirement for additional examiner contracts to cover the extra workload and increase in examination sessions throughout the province. This would create a higher financial impact for the Branch as there is no licence fee for first responders to offset the cost. In fiscal 2020/21 the cost for examinations was $127,721.

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**Approved:**

June 4, 2021 – Brenda Rafter, A/Executive Director obo Philip Twyford, ADM, Finance and Corporate Services Division
June 7, 2021– Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## College of Dental Hygienists – Quality Assurance Program Updates

### TOPIC

- In 2021 the College of Dental Hygienists of BC (CDHBC) amended its Quality Assurance Program (QAP) by bringing the development and administration of its QAP examination in-house to the college. The CDHBC implemented the change with the intent to shift the examination's focus from entry to practice knowledge to real life practice issues specific to dental hygiene practice in BC following a 2018 review of the QAP.
- Between 2013 and 2021 the CDHBC used the National Dental Hygiene Certification Board (NDHCB)'s quality assurance examination.

### CURRENT SITUATION

- The CDHBC launched the new version of the QAP examination in January 2021, following a review of the QAP.
- The new examination has fewer questions (70 instead of 75), has a reduced cost ($85 instead of $125) and registrants have more time to complete it (3 hours instead of 2.5 hours). Like the previous NDHCB examination, registrants are only required to take the examination every five years.
- Between February and March 2021, the Ministry received 22 letters from dental hygienists raising concerns about the QAP examination and requesting its discontinuation or revision. The letters were sent to the CDHBC, with copies also sent to various Ministry officials and politicians.
- Additionally, a petition (https://www.change.org/p/john-horgan-registered-dental-hygienists-want-the-qap-exam-gone) was also formed on March 11, 2021, opposing the changes to the QAP program. As of May 13, 2021, the petition has received 2841 signatures.
- In addition to QAP concerns, some of the incoming letters also commented that the CDHBC's registration requirements are overly onerous and expensive, especially when compared to those of other provincial dental hygiene regulators. The writers of these letters identify the QAP examination as a further financial and academic burden.
- Concerns relating to the QAP include:
    - It is more extensive and challenging than the QAPs of other health professions and is not commensurate with the risk level of activities performed by dental hygienists and the number of reported incidents of malpractice.
    - The QAP examination is an inadequate tool for assessing competency.
    - The costs of the QAP examination.
    - The current version of the QAP examination is more difficult than the previous version.
- The CDHBC has defended its QAP examination, which it views as an efficient tool to assess competency and thus necessary for protecting the public. The CDHBC has published resources (https://www.cdhbc.com/Professional-Development/Quality-Assurance/QAP-Assessment-Tool.aspx) on their website enumerating the differences between the 2013 and 2021 versions of the examination; outlining the process of developing the new examination; and providing a rationale for the methods chosen and the changes implemented.
- Within its published resources, the CDHBC has outlined that success rates on the new QAP examination are similar to those of the former examination.

### KEY FACTS

- Under section 19(1) (m) of the HPA, regulatory colleges may make bylaws to establish conditions and requirements of registration for registrants. The CDHBC's initial registration and renewal requirements are comparable to dental hygienist regulators in Alberta and Ontario. The core fees related to initial registration differ between the three provinces, being the lowest in Alberta and the highest in Ontario (for example, core registration fees for a new graduate are $1460 in Alberta, $1870 in BC, and $3642 in Ontario, not including liability insurance).
- Administering QAPs is a core component of a college's role under the *Health Professions Act* (HPA). The purpose of QAPs in health professions is to maintain high quality care and competency by identifying and

addressing practice gaps. They are not intended as a punitive measure towards registrants. Under section 16(2)(e) of the HPA, regulatory colleges are required to establish and maintain a continuing competency program to promote high quality practice standards amongst registrants. To meet this objective, a regulatory college may make bylaws establishing a QAP.

- The HPA does not specify the content and format of a QAP. Regulatory colleges can set their own criteria as long as they comply with the duties and objects of colleges outlined by the HPA.
- Section 26.1 of the HPA specifies that a college may require that a registrant complete further education and training if practice gaps are identified during the quality assurance process. The HPA does not provide colleges the authority to revoke or suspend a registrant's licence until allegations of incompetent practice are reviewed by the college's inquiry committee.
- The CDHBC's QAP consists of a 5-year cycle starting with registrants taking the examination and then completing learning activities that are chosen or assigned depending on their performance. Registrants who do not pass the examination are required to undertake directed learning under the supervision of an assessor.
- The CDHBC replaced its former Continuing Competency Program with a QAP in 2013. The Continuing Competency Program did not have an assessment component. Registrants were only required to do self-directed learning.
- Health profession regulatory colleges in BC take different approaches to quality assurance. The majority of colleges do not use examinations to assess competency. Some colleges (e.g. the College of Physical Therapists of BC) perform random practice assessments and audits, while others (e.g. the College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC and the College of Dental Surgeons of BC) solely rely on self-directed learning.
- Dental hygienist regulators' QAP programs also differ across jurisdictions. The College of Registered Dental Hygienists of Alberta requires self-directed continuing education and the completion of certain practice hour requirements. The College of Dental Hygienists of Ontario allows registrants to choose between continuous education or taking a written examination to assess their knowledge and assesses registrants' skills and judgment either through self-assessment or onsite practice review.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
June 8, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Community Bargaining Association Collective Agreement

### TOPIC

The Community Bargaining Association (CBA) and the Health Employers Association of BC (HEABC) 2019-2022 Collective Agreement.

### CURRENT SITUATION

The CBA and HEABC reached a tentative agreement on June 12, 2018; the agreement was fully ratified on July 27, 2018. The agreement was reached under the 2019 Sustainable Services Negotiating Mandate.

### KEY FACTS

- The CBA collective agreement covers approximately 17,091 active employees, or 10,983 Full Time Equivalents (FTEs), and represents an estimated $675 million in annual expenditure on compensation.[1]
- The eight-union CBA includes members from the BC Government and Service Employees' Union, the Hospital Employees' Union, the United Food and Commercial Workers' Union, and the Health Sciences Association. The BC Government and Service Employees' Union represents the largest number of CBA members at approximately 7,040 FTEs (64% of total CBA FTEs).[2]
- CBA members provide support services in various community settings including private homes, group homes, residential community living homes, assisted living facilities, supported employment programs, child development centres, adult day programs, mental health centres, substance use programs, and community service agencies throughout BC.
- Community health workers (comparable to health care assistants covered by the Facilities Bargaining Agreement) make up the largest occupational group within the CBA. Community health workers are employed to provide home support services through contracted agencies and directly for the province's health authorities.
- Community subsector employers pay 100% of the premiums for dental, extended health, group life and long-term disability insurance.
- Regular community subsector employees and their employers contribute to a defined benefit pension plan, the Municipal Pension Plan.

<u>COVID-19 Pandemic Single Site Order</u>

- As a result of COVID-19 outbreaks in long-term care and assisted living facilities, the Provincial Health Officer issued Single Site Orders, limiting the movement of staff between facilities.
- Facilities covered by the order includes: long term care facilities, private and public hospitals, provincial mental health facilities and assisted living facilities.
- CBA health care workers working in a facility covered under the order are subject to the limitation to work at only one site.

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

- The CBA and HEABC ratified a new three-year collective agreement on July 27, 2018 under the Sustainable Services Negotiating Mandate.
- Highlights of the agreement include:
    - General wage increases of 2% annually in 2019, 2020, and 2021.
    - Changes to scheduling and casual call-in procedures to support improved continuity of care.
    - The ability for employers to fill temporary vacancies of up to nine months (increased from four months) through an expedited process.
    - Establishment of a task force on optimization of community health worker work and scheduling to improve the alignment of work distribution and resources with current and future home care delivery models.

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[1] PSEC Public Sector Compensation Annual Forecast 2019 (unreleased) pg. 33

[2] Ibid.

- Establishment of a joint committee to undertake a review of compensation for CBA occupations compared to similar occupation under the Facilities collective agreement with targeted funding of $40 million over the three-year agreement to close existing wage gaps and address staff turnover.

## FINANCIAL IMPLICATIONS

- The CBA collective agreement represents an estimated $675 million in annual expenditure on compensation.
- A 1% increase to compensation represents approximately $6.75 million.[3]

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**Approved:**
January 25, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
February 8, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

[3] PSEC Public Sector Compensation Annual Forecast 2019 (unreleased), pg. 33

# LEGISLATIVE SESSION - FACT SHEET

## Contracting FPs and NPs into Primary Care Networks

### TOPIC

In support of the Primary Care strategy, the Ministry of Health has allocated funding for Family Physician (FP) and Nurse Practitioner (NP) positions with the goal of increasing patient attachment, access, and quality of care. Service Contracts for FPs and NPs were introduced in 2018 to support recruitment into these positions.

### CURRENT SITUATION

- Between September 2019 and July 2020, the Ministry and Doctors of BC consulted on the development of a new Group Contract for Practicing Full-Service Family Physicians (Group Contract for FPs).
- As part of the consultation process, the FP Contract originally introduced in 2018 for FPs without an existing panel, now known as the New-to-Practice Contract (NTP), was revised to align with the new Group Contract for FPs.
- Physicians who have signed the previous version of the FP Contract will have the option to transition to the NTP Contract.
- The new Group Contract for FPs and the NTP Contract were announced in October 2020.

### KEY FACTS

- Building on investments by the General Practice Services Committee (GPSC) to support FPs, regional health authorities have been working with Divisions of Family Practice and the First Nations Health Authority locally to undertake implementation of PCNs that are made up of team-based care clinical service models (PMHs, UPCCs, CHCs, NPPCC and FNPCCs).
- The integrated system of primary care envisions a system that is coordinated with all practitioners working to full scope. This approach allows patients access to a full range of healthcare options, streamlining referrals between providers, and providing better support to FPs, NPs, and other members of a patient's care team.
- As part of the PCN Service Plan approval process to fund FPs and NPs, a total of 362.9 FTEs have been approved over the next 4 years. The following FP and NP FTE's have been approved to date:
  - Year 1 PCN approvals FPs = 121.45 FTEs over 4 years; NPs = 85.00 FTEs over 4 years.
  - Year 2 PCN approvals FPs = 93.40 FTE over 4 years; NPs= 63.05 FTEs over 4 years.
- As of March 3, 2021 (Period 12 of Fiscal Year 2020/21):
  - 39 FPs have signed Group and NTP Contracts, the latter contract specifically developed to newly attach British Columbians who are otherwise unattached, to work as part of a team based PCN (23 FTEs), including: 12 FPs in Chilliwack and Fraser Health Rural PCNs (2.9 FTEs), 1 FPs in Cowichan Valley PCNs (0.5 FTEs); 2 FPs in East Kootenay PCNs (0.4 FTEs), 10 FPs in Vancouver PCNs (7.5 FTEs), 4 FPs in Western Communities PCNs (2.5 FTEs; including 3 FPs on a 1.5 FTE group contract with the High Complexity Care Team); 2 FPs in Burnaby PCNs (2 FTEs); 7 FPs in Fraser Northwest PCNs (6.4 FTEs); 1 FP in the Nanaimo PCN in Planning (0.5 FTEs)
  - 101 NPs have signed Contracts to work as part of a team based PCN (99 FTEs), including: 6 Early Draw NPs as part of PCNs in Planning or Pre-Planning (6 FTEs), 19 NPs in NP Primary Care Clinics (19 FTEs), 34 NPs in Year 1 PCNs (34 FTEs), and 42 NPs in Year 2 PCNs (40 FTEs). An additional 17 NPs (17 FTEs) are on salary agreements in PCNs.
- The Contract requires practitioners to agree to become part of the PCN in their community and to adopt the attributes of the Patient Medical Home[1].
- For NTP Contracts, recruitment is targeted to FPs and NPs who do not currently have a patient panel and the Contracts provide income security as practitioners build their patient panel.
- Practitioners commit to act as the most responsible primary care provider for a patient panel that is balanced (e.g., age, complexity). Panel size targets increase during the term as follows, for 1.0 FTE:
  - FPs: 800 patients in year 1 of the term and 1,250 patients in year 2

[1] 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 in the Contract as:
  - 1,680 to 2,100 hours and to ensure continuity of care over the year, each FTE FP may work a maximum of 90 hours over two weeks and,
  - a minimum of 1,680 hours and a minimum of 220 days per year for NPs.
- Practitioners are expected to join an existing group practice or establish a group practice.
- FP payment rates per 1.0 FTE under the revised FP Contract are as follows:
  - Year 1: $275,057-$285,257 (base rate inclusive of overhead, and a $10,200 year-end bonus for completing QI activities and achieving the panel attachment target)
  - Year 2: $275,057 - $295,457 – (base rate inclusive of overhead plus $20,400 for achieving QI).
- For NPs, the annual 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.

**FINANCIAL IMPLICATIONS**

- *Budget 2021* includes $253M over 3 years ($63M; $95M; $95M) to continue to expand team-based and urgent primary care. This builds on funding allocated in *Budget 2018* to support recruitment of primary care health professionals for team-based care (including additional GPs and NPs) and to pilot innovation hubs.
- *Budget 2018* year-3 allocation of $153M continues as part of the Ministry's base budget ($458M over 3 years). Total net new funding for the Primary Care Strategy is $711M over 3 years ($215M/ $248M; $248M).

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**Approved:**

May 17, 2021 –Kerri Harrison obo Philip Twyford, ADM, Finance and Corporate Services Division
June 9, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Criminal Record Checks for all Emergency Medical Assistants in BC

### TOPIC

The requirement for Criminal Record Checks (CRC) for Emergency Medical Assistants (EMAs) in BC has been discussed since 2008. The EMA Licensing Board has created a policy to require CRCs for all licence levels, which brought upon some opposition from the Fire Fighters Union. The policy has been updated to reflect the consultation and subsequent meetings with the Union.

### CURRENT SITUATION

- As of September 1, 2020, all initial applicants for an EMA licence are required to submit a CRC that is completed within 3 months of the licence application.
- No complaints or other comments have been received as of September 16, 2020.

### KEY FACTS

- The Board is authorized under the *Emergency Health Services Act* to protect the public through the examination, registration, and licensing of EMAs in BC while setting terms and conditions for a licence and investigating complaints about EMAs. The EMA Licensing Branch supports the Board and is part of the Health Sector Workforce and Beneficiary Services Division in the Ministry of Health.
- There has been interest in the creation of a requirement for a CRC for EMAs as part of the licensing process for over a decade since the Office of the Comptroller General first raised the issue in 2008.
- Based on strong legal authority to require CRCs for initial licensure, and some conflicting legal authority to require a CRC for licence renewals, the Branch developed a Determining Good Character Policy, which the Board approved June 6, 2019.
- On July 16, 2019, the Board notified EMAs and their employers of an upcoming policy change requiring initial licences and licence renewals to obtain a CRC.
- Since then, the Board received feedback from some stakeholders expressing concerns about the policy.
- In order to provide a greater opportunity to receive and consider potential stakeholder feedback, the Board placed the implementation of this policy on hold while it undertook a 90-day consultation on the policy ending November 24, 2019.
- Following the conclusion of the feedback period, the Board has considered the full range of feedback received and decided to move forward with implementation of the policy.

**Background**

June 2018 - June 2019

The Board approved the implementation of CRCs at the points of initial licensure and licence renewal to ensure the Board was meeting its statutory mandates. The implementation date was set for September 2018 but was delayed as a privacy impact assessment (PIA) needed to be developed and approved. The PIA was signed off on June 21, 2019. In addition, a service agreement to conduct CRCs online with Sterling Talent Solutions was reviewed by legal and approved in June 2019.

July 2019

The Board approved the policy that required CRCs for initial licences and licence renewals.

- All EMAs and employers were notified that effective September 1, 2019 for initial and reinstatements, and October 1, 2019 for renewals, a CRC would be required.
- In response to the notification, the Fire Chief's Association of BC (FCABC) raised concerns about their budgets, and the International Association of Fire Fighters (IAFF) raised concerns about privacy. The IAFF threatened legal action if the Board did not change its policy.
- The Board did not receive any negative response from BC Emergency Health Services or the Ambulance Paramedics of BC (CUPE 873).

# LEGISLATIVE SESSION - FACT SHEET

August 26, 2019

In response to the FCABC's and the IAFF's concerns, the Board put the implementation of the policy on hold while it undertook a 90-day consultation period with stakeholders. Feedback on the policy and the requirement to collect CRCs was requested via email to all EMA's and key stakeholders, as well as posted on the EMA Licensing website.

November 24, 2019

The consultation period ended, and the Board received 133 responses from the public, health regulators, first responders, and paramedics. The key themes that came from the consultation included:

- General misunderstanding of the frequency the CRCs would be required
- Duplication between employer and EMA Branch licensing requirements
- Time commitment
- A FAQ document would be appreciated

January 28, 2020

- Upon considering the results of the consultation, the Board made the following decisions:
    - Applicants will be required to complete a CRC at the time of initial licensure and for the reinstatement of expired licenses;
    - Applicants will not be required to complete a CRC at the time of renewal;
        - In order to fill the information gap this will cause, the Branch will – at the time of renewal – check the publicly available BC Courts online website for any relevant information concerning the individual applying for renewal. This is not a CRC, and will require no action or payment on the part of the applicant;
    - Make a request to all employers to provide to EMALB information about criminal charges respecting a licensee as soon as it is known to them.
    - Make a request to government to revise EMA regulations to provide clear legal authority for the EMAL Board to require a CRC at all license stages.
- The EMAL Board's decisions were communicated to the FCAB and IAFF on January 28, 2020.
- In response, the IAFF expressed further opposition to:
    - The requirement for a CRC on both renewal and initial licensure;
    - 4 of 11 questions on the licence/renewal application form (which is not a CRC):
        - Whether the applicant has been charged with or convicted of a criminal offence;
        - Whether the applicant is currently under investigation by another licensing organization;
        - Whether the applicant has been suspended or fired by their employer for a criminal offence;
        - Whether the applicant knows of anything else which may negatively impact their eligibility to become licensed.

April 1, 2020

- In response to the IAFF's concerns the Branch has created an application for licence renewal form that does not have the applicant questionnaire included. The initial application for licence form still contains the questionnaire.
- The Board implemented the CRC requirements for licence reinstatement on April 1, 2020. If an EMA applies for reinstatement within 90 days of licence expiry, the CRC requirement may be waived.

## FINANCIAL IMPLICATIONS

- No financial impact to the Ministry.
- EMAs are responsible for criminal record check costs.

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**Approved:**

February 16, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division
June 8, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Diagnostic Facility Access for Complementary and Alternative Medicine Practitioners

### TOPIC

- Diagnostic imaging: Complementary and alternative medicine (CAM) practitioners who are regulated health professions under the *Health Professions Act* (HPA), such as naturopathic doctors (NDs) and chiropractors, are authorized to order diagnostic imaging services through their scopes of practice. These services are not a covered benefit under the Medical Services Plan (MSP) when ordered by these practitioners.
- Laboratory testing: NDs are authorized to order laboratory tests through their scope of practice and College of Naturopathic Physicians of BC's (CNPBC) standards, limits, and conditions. These services are not a covered benefit under MSP when ordered by these practitioners.

### CURRENT SITUATION

- Since 2018, the BC Chiropractors Association (BCCA) has advocated to the Ministry and Minister (both in writing and in person) for chiropractors to have enhanced access to the following diagnostic services: 1) the ability to directly order X-rays and have them covered by MSP, (2) access the health authorities' Picture Archiving and Communication Systems (PACS), and (3) to order select laboratory tests and access the results.
- The BCCA argues that granting chiropractors access to these following diagnostic services would reduce additional patient visits and examination costs, and patient delays in receiving care.
- On May 11, 2020, the BCCA wrote to the Ministry requesting direct referral of patients to diagnostic imaging by chiropractors due to COVID-19. The BCCA argued the COVID-19 backlog for patients to see a medical practitioner to obtain a diagnostic imaging referral would result in a delay in chiropractic patient care, as patients would need to book additional visits with medical practitioners who are reimbursed for ordering imaging under MSP.
- In addition, the BCCA requested chiropractors be granted permission to access the Provincial eHealth Viewer in order to view patient results to minimize wait times for patients.

### KEY FACTS

<u>Diagnostic Imaging</u>

- The ability to order diagnostic imaging for a patient is considered a restricted activity under the HPA. Authorization for restricted activities is granted under a profession's regulation under the HPA.
- Physicians, dentists, podiatrists, midwives, nurse practitioners and certain certified practice registered nurses are authorized to order diagnostic imaging services under their scopes of practice; however, only physicians/specialists are reimbursed through MSP.
- CAM regulated health professionals can order select diagnostic imaging services as part of their scope of practice; however, these services are not reimbursed through MSP:
    - Chiropractors (x-rays, CTs and MRIs),
    - NDs (x-rays (excluding CTs) and ultrasounds (including application to a fetus).
- Since NDs and chiropractors are not insured under the *Medicare Protection Act* (MPA), patients must pay out of pocket if the ND or chiropractor orders imaging services. If the patient is unable to pay, the patient must ask a health professional who is insured under the MPA, such as a physician, to order the test for it to be covered.
- Evidence-based clinical practice guidelines, such as BC Guidelines,[1] do not recommend routine diagnostic imaging of the lower-back except in limited cases where there is a clinical supsicion of a serious pathology (e.g. suspected cancer).
- On July 15, 2020, the College of Chiropractors of BC (CCBC) announced on their website that due to the results of a research review they requested on the use of routine and repeat spinal radiography, such as x-rays, they would be amending the Professional Conduct Handbook as a result.[2] The review of the clinical

[1] https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/appropriate-imaging
[2] https://www.chirobc.com/review-of-clinical-utility-of-routine-spinal-radiographs/

research found no evidence that the routine/repeat use of x-rays to assess spine function or structure (in the absence of clinical suspicion of a serious pathology) improves clinical outcomes for the patient.[3]

- On August 11, 2020, the CCBC posted on their website the draft amendments to the Handbook on the use of x-rays. Over 1,000 responses were received by the deadline of September 8, 2020, many concerned about the elimination of chiropractors' ability to use radiography. The CCBC clarified on their website they have no intention to eliminate the use of radiography, and the purpose of the review is to analyse the clinical utility of routine and repeat spinal radiographs with the proposed aim of limiting its use to "red flag" cases.
- On payment of a fee to cover costs, patients of chiropractors are entitled under the *Hospital Act Regulation*, Section 6(2), to obtain copies of any x-ray prepared in a hospital or supplied to a hospital by a medical doctor (but not the accompanying x-ray report) and to then give those copies to their chiropractor. These can be accessed through the health authority's PACS.
- Currently only the Vancouver Island Health Authority has granted chiropractors access to PACS. Where the chiropractor has not registered with PACS or is otherwise unable to access existing diagnostic images online, the patient can contact the diagnostic facility that took the x-ray and request a copy of their x-ray report. When images are requested by a patient, a copy fee is charged. This does not create additional MSP costs for unnecessary medical doctor visits.

Diagnostic Facilities in BC

- All diagnostic facilities in BC must be accredited through the Diagnostic Accreditation Program (DAP), which is overseen by the College of Physicians and Surgeons of BC (CPSBC).
- Both public and private diagnostic facilities must have DAP accreditation to receive Medical Services Commission approval to bill MSP. DAP accreditation requires that a CPSBC registrant must be the facility director, in effective control of its operation and administration, and ensure that procedures are performed only in accordance with CPSBC's standards of ethical conduct.

Laboratory Test Ordering

- The ordering of diagnostic laboratory tests, and the health care practitioners who are reimbursed through MSP for diagnostic test ordering, is governed under the *Laboratory Services Act* (LSA) and its regulation.
- Physicians, dentists, podiatrists, midwives, nurse practitioners and certain certified registered nurses are authorized under the LSA to order laboratory tests; however, only physicians and specialists are reimbursed through MSP.
- Although requested by BCCA, it is unclear whether ordering lab tests would align with a chiropractor's current scope of practice.
- NDs are authorized to order laboratory tests through their scope of practice and CNPBC standards. Since NDs are not authorized for MSP coverage under the LSA , patients must pay out of pocket for lab tests ordered by NDs. If a patient can not afford to pay out of pocket, NDs can refer their patients to a health professional recognized under the LSA, who is willing to issue a requisition to have it accepted in a BC diagnostic facility and covered as an MSP benefit.

## FINANCIAL IMPLICATIONS

N/A

**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[3] https://chiromt.biomedcentral.com/articles/10.1186/s12998-020-00323-8

# LEGISLATIVE SESSION - FACT SHEET

## Diagnostic Medical Sonography

### TOPIC

- Diagnostic Medical Sonography uses high-frequency sound waves to generate images of anatomy and pathology in hospital and clinic settings. Areas of specialization include cardiac and general sonography. Some sonographers perform services in both areas.
- Health authorities continue to experience challenges recruiting and retaining diagnostic medical sonographers (sonographers) in the public health care system.

### CURRENT SITUATION

- Sonographers were identified in government's *Labour Market Outlook: 2019 Edition* as a high demand health occupation in BC.[1] The Ministry of Health's provincial health workforce planning process identified sonographer as a priority profession with labour market challenges. Sonographers are also in high demand as a result of surgical renewal efforts.
- The BC Institute of Technology (BCIT) offers a 40 seat, 27-month diploma program with 46 weeks of clinical experience. BCIT has been funded for an additional 8 seats in February 2021, which will result in 48 seats offered annually through BCIT at steady state. Students train in general or cardiac sonography or a dual general/cardiac option. BCIT is not anticipating any impacts on student numbers due to COVID-19.
- The College of New Caledonia (CNC) in Prince George launched a 24-month diploma program in January 2019 with a one-time cohort of 8 students. A full cohort of 16 students was launched in September 2019. This program will continue to offer 16 seats annually each September and trains students in general and cardiac sonography. CNC has not experience any reduced student numbers due to COVID-19.
- Camosun College will launch their new sonography program in May 2021, a 1-year delay from their original date of May 2020, due to COVID-19. This program will contribute to the provincial supply of sonographers with an annual cohort of 16 students.
- Based on 2020 graduate numbers from the BCIT program (40), it is expected sonography graduates in BC will double to 80 by 2023 as a result of the new programs and seat expansions.

<u>Supply of Sonographers</u>

- In 2019 there were 703 (455 FTEs) sonographers working in the public health sector. Of these sonographers 625 (374 FTEs) worked as general sonographers and 160 (81 FTEs) provided services in echo-cardiac ultrasound (the sum of general and echo-cardiac sonographers is less than the total of all sonographers, as those who work in both roles are counted only once in the total figure). Over the past 5 years, there has been, and continues to be, increasing numbers of sonographers in the public workforce.[2]
- Health authorities are concerned about ultrasound waitlists due to challenges recruiting sufficient numbers of of sonographers and radiologists.
- The Ministry's Provincial Health Workforce Strategy identified several factors impacting supply including the increasing role of private imaging clinics, injury rates, demographics and the distribution of sonographers in the province.[3]
- Sonographers experience high rates of musculoskeletal injury due to the repetitive nature of their work. This can result in absences, long term disability and in some cases career-ending injury.[4]Health authorities suggest compensation disparity with private providers and other provinces significantly impacts the supply of sonographers in BC's public health system. The table below shows wage rates for publicly funded sonographer positions in Canada, as of April 1, 2018.[5]

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[1] Labour Market Outlook: 2019 Editionhttps://www.workbc.ca/getmedia/18214b5d-b338-4bbd-80bf-b04e48a11386/BC_Labour_Market_Outlook_2019.pdf.aspx., accessed June 17, 2020

[2] 2018 Health Human Resource Occupations, Data for All Employers Reporting in HSCIS, Health Employers Association of BC. November 20, 2019.

[3] BC Provincial Health Workforce Strategy 2018/19-2020/21

[4] BC Provincial Health Workforce Strategy 2018/19-2020/21

[5] Larry Chang, Economist, HEABC, email March 22, 2018

| Province | Hourly Rate | | | Ranking of Top Wage |
|---|---|---|---|---|
| | Starting Wage | Wage 6th Year | Top Wage | |
| BC | $30.84 | $38.43 | $38.43 | 4 |
| AB* | $39.27 | $47.46 | $50.64 | 1 |
| SK* | $42.05 | $45.05 | $45.05 | 2 |
| MB | $37.58 | $43.58 | $43.58 | 3 |
| QC | $22.74 | $31.81 | $32.93 | 9 |
| NB | $26.85 | $33.67 | $33.67 | 8 |
| NS* | $29.95 | $34.95 | $34.95 | 6 |
| PEI | $30.52 | $37.44 | $37.44 | 5 |
| NL* | $27.50 | $34.59 | $34.59 | 7 |
| ON** | N/A | N/A | N/A | N/A |

* Data from collective agreement that expired before April 1, 2018. Rates are based on the latest information at the time of printing.
** Data from Ontario is not available.

- In a report covering Q4 of 2019, 16 diagnostic medical sonographer vacancies were considered difficult to fill, which equates to a 3.09% vacancy rate.[6]

## KEY FACTS

- Since December 2012, applications for new, expanded or relocated outpatient diagnostic ultrasound facilities, both publicly and privately owned, have been under a moratorium. The moratorium has been extended to June 1, 2022 and seeks to address the significant shortage of publicly employed sonographers in BC.
- New sonography programs at CNC and Camosun, as well as additional seats at BCIT, are expected to improve BC's supply of sonographers. However, program expansion and COVID-19 have created increased pressure on clinical placement opportunities. The Ministry is working closely with the Ministry of Advanced Education and Skills Training (AEST), health authorities and other key stakeholders to support sonography education expansions and clinical placement capacity.
- The Ministry is working with AEST, Island Health, and Camosun College to develop a teaching clinic on the Camosun campus that will help alleviate pressues on provincial placement opportunities.
- Sonographer is an eligible profession under AEST's Loan Forgiveness Program. Sonographers working in a designated underserved community can apply for loan forgiveness on the outstanding BC portion of a Canada-BC integrated student loan at a rate of up to 20% per year for up to 5 years.[7] Refer to the BC Loan Forgiveness Program Fact Sheet for further information.

## FINANCIAL IMPLICATIONS

- In January 2020, the AEST announced government funding of approximately $2.5M in expansions and upgrades to the sonography program at BCIT. This funding is comprised of $880K to support the expansion of BCIT's Diagnostic Medical Sonography and Cardiovascular Perfusion programs, and $1.6M for sonography equipment.[8]
- In October 2019, AEST also announced government one-time funding of $1.4M to support Vancouver Island's first Diagnostic Medical Sonography program at Camosun College Camosun starting in May 2021.[9]

**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 12, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 21, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[6] HEABC Difficult to Fill Vacancy Report 2019 Q4, April 01, 2020
[7] BC Student Loan Forgiveness https://studentaidbc.ca/repay/repayment-help/bc-loan-forgiveness-program, accessed January 24, 2020
[8] BC Gov News Release, Jan 8, 2020: https://news.gov.bc.ca/releases/2020AEST0001-000016

# LEGISLATIVE SESSION - FACT SHEET

## Emergency Health Provider Registry

### TOPIC

The Emergency Health Provider Registry (EHPR) enables the voluntary registration and deployment of health care providers during an emergency in BC to support vital health services.

### CURRENT SITUATION

- HealthLinkBC manages the day-to-day operations of the EHPR, which is a secure SharePoint platform of health care providers who have voluntarily registered for potential deployment or employment to an area impacted by a local, regional or provincial emergency (e.g. wildfire, flood, pandemic), where existing health human resources require further support.
- In early 2020, with the onset of the COVID-19 pandemic, a 2nd component was added to the EHPR and the Ministry requested certain regulatory colleges and professional associations reach out to their registrants/members to sign-up with the 'COVID-19 EHPR', with a focus on those recently retired or practitioners affected by private practice closure. For those retired or non-practicing, regulatory colleges offered 'temporary emergency registration' or reinstatement to those who met the eligibility requirements.
- Multiple call outs have been made to health professionals through the regulatory colleges and professional associations since the beginning of the pandemic, to solicit individuals who would be able to support the COVID-19 response.
- In addition, there have been a number of updates to the EHPR, which streamline the information being collected, add additional categories to support immunization (such as whether they have had immunization training), and clarify registrant information, such as the region where they currently reside.
- In February and March 2021, the Ministry publicly called on potential health care providers who would be able to support COVID-19 immunization efforts to register on the EHPR, so that health authorities (HA) had a centralized list of individuals to contact for these roles.
- The number of individuals who have registered in response has been significant, and in response the Ministry is collecting weekly spreadsheets of individuals who have recently registered (within the week) and is providing the lists directly to regional HAs. Each HA receives a list of registrants who live within their geographic region (so for example, Vancouver Coastal Health receives individuals who only live in the region), who are able to either provide immunizations or support their provision based on expanded scope outlined within Provincial Health Officer Orders.
- As of May 28, 2021:
    - There are a total of 10,882 active registrants on the EHPR. Of those, 10,477 registrants have registered for COVID-19 specific deployment.
    - A total of 9,398 registrants are eligible to deliver vaccinations (includes all HA and non-HA employed registrants where immunization is included in their scope of practice or covered under the PHO order).
    - The information of 6,802 registrants who are eligible to deliver vaccinations and are not already employed by a HA were sent to HAs as follows ('blank' indicates registrants sent prior to an update to the EHPR which required them to indicate their HA of residence):

| HA Residence of non-HA Employed Registrant | Immunizer Eligibility In Scope | PHO Order | Grand Total |
|---|---|---|---|
| FHA | 507 | 950 | 1457 |
| IHA | 287 | 573 | 860 |
| NHA | 33 | 104 | 137 |
| VCHA | 462 | 862 | 1324 |
| VIHA | 390 | 707 | 1097 |
| (blank) | 1866 | 17 | 1883 |
| **Grand Total** | **3545** | **3213** | **6758** |

**Response to the COVID-19 Pandemic**

- On March 17, 2020, BC declared a state of emergency to support a province-wide response to COVID-19.
- Prior to this declaration, the EHPR was only available to health care providers employed in an HA, notwithstanding physicians.

- To support the pandemic response, the EHPR was expanded to include providers working outside of an HA including:
  - those employed in the private sector (e.g., physiotherapists and social workers); and
  - individuals that received temporary emergency licensing or registration from a health regulatory college or professional association in BC (e.g., recently retired nurses).
- Prior to the COVID-19 pandemic, registration to the EHPR was done via calling 8-1-1. To ensure 8-1-1 services were available to the public during the pandemic, an online registration avenue to volunteer was developed for new COVID-19 registrants.

## KEY FACTS

- The EHPR was initially created in July 2017, to support BC's provincial state of emergency due to unprecedented wildfire activity in the province.
- At the time, HAs identified the need for a secure, shared provincial registry of health care providers willing to be redeployed to provide care in impacted communities.
- In response, the Ministry (HealthLinkBC, Health Emergency Management BC and Health Sector Workforce and Beneficiary Services Division) created the primary architecture for the "Wildfire Registry." This work included principles and processes for activation, communication, and compensation and staffing, under the authority of the *Emergency Program Act*.
- HealthLinkBC led the development of the database on a secure SharePoint site and interested registrants phoned 8-1-1 to register.
- In 2018, several key improvements were made to the Wildfire Registry which was then renamed the Emergency Health Provider Registry (EHPR) and:
  - considered redeployment to include emergencies over and above wildfires;
  - streamlined the registration process;
  - aligned with a provincial credentialing process for physicians; and
  - enhanced data collection and reporting.
- In 2020, further enhancements were added to the EHPR including the addition of online registration, resulting in two components to the EHPR: "Wildfire Registry" and "COVID-19 Registry."
- The EHPR includes contact information, current HA of employment (if applicable), employment details, preferred HA(s) for deployment (if not a current HA employee), professional designation, training and availability.
- Annually (generally early spring before wildfire and flood season), all existing registrants are asked to contact HealthLinkBC to re-confirm the accuracy of their registration and their continued interest in being a registrant.
- Health Emergency Management of BC, with the support of HealthLinkBC, is responsible for activating/deactivating the EHPR. Activation can occur at the request of an HA; or when an emergency event creates the potential for staffing challenges that could impact operations in one or more HAs.
- During an emergency, only HAs can directly access the EHPR database to request assistance from nurses, allied health professionals and physicians on the registry.
- Work is currently underway to develop a more comprehensive EHPR ("v 2.0"), with greater flexibility built-in to accommodate all anticipated emergencies in the future including consideration of a new database, search functionality and associated budget.

## FINANCIAL IMPLICATIONS

- In 2020/21 $15,600 was spent to redevelop the EHPR solution to support the Province's COVID-19 response.
- EHPR operating costs are managed under the HealthLinkBC budget.

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**Approved:**

April 26, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
June 2, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 7, 2021 – Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Emergency Medical Assistants Licensing Board - Actions Taken to Support COVID-19

### TOPIC

During the COVID-19 pandemic the Emergency Medical Assistants Licensing Board acted to protect the public by limiting disruption to the examination, registration, and licensing of Emergency Medical Assistants.

### CURRENT SITUATION

Practical examinations have again been cancelled in all 5 locations across BC. At this time, they are set to resume June 15, 2021, starting in Victoria.

### KEY FACTS

- The Board is authorized under the *Emergency Health Services Act* to protect the public through the examination, registration, and licensing of Emergency Medical Assistants (EMAs) in BC, while setting terms and conditions for a licence, and investigating complaints about EMAs. The EMA Licensing Branch supports the Board and is part of the Health Sector Workforce and Beneficiary Services Division in the Ministry of Health.
- March 18, 2020 - The Minister of Public Safety and Solicitor General declared a state of emergency throughout BC to support the provincewide response to the novel coronavirus (COVID-19) pandemic, under the *Emergency Program Act*.
- April 8, 2020 - The Minister of Public Safety and Solicitor General signed an order allowing regulatory authorities that have a statutory power of decision to waive, suspend or extend a mandatory time period relating to the exercise of that power during the state of emergency.
- March 15 – 31, 2020 - Institutions that run EMA training programs closed down for in-person classes, which included all Branch contracted practical examination locations. In addition, BC Emergency Health Services (BCEHS) paused all training institution precepting, halting the ability for Primary Care Paramedics (PCPs) to complete their programs. Some Advanced Care Paramedics were still able to complete their precepting.
- July 2020 - Institutions resumed training programs online and face to face, and BCEHS resumed PCP precepting.

**Examinations**

- Practical exams for EMAs are required for both EMR and PCP licence categories. Examinations are routinely conducted by the Branch in Victoria, Vancouver, Vernon, Cranbrook, and Dawson Creek.
- April 8, 2020 - All EMA examination applicants currently in the system were given a 6-month extension on their evaluation files. The normal timeline for examination completion is 12-months, and was extended to 18-months.
- April 9, 2020 - All scheduled practical exams in BC were cancelled for April and May.
- May 27, 2020 - The Canadian Organization of Paramedic Regulators conducted the entry to practice examination using virtual proctoring for the first time. The exam was originally scheduled to take place in person on May 13, 2020.
- June 1, 2020 - EMA practical exams resumed in Victoria only and were being conducted in smaller groups of three applicants with WorkSafe BC COVID safety protocols in place.
- August 2020 – EMA practical exams resumed in Vancouver, Dawson Creek, and Vernon with extra safety precautions. The Cranbrook location has not reopened.
- November 19, 2020 – The Provincial Health Officer Order suspending all events and gatherings related to social interactions and travel resulted in all practical examination sessions across the province being cancelled.
- December 2020 – All Vancouver Island residents completed their practical examinations in small groups at the EMA Licensing Victoria office.
- February 2021 – Practical exams resumed through out the province and examinations were conducted in Victoria, Vancouver, and Vernon.

- April 2021 - The Provincial Health Officer Order suspending all events and gatherings related to social interactions and travel resulted in all practical examination sessions across the province being cancelled.
- May 19, 2021 – the Canadian Organization of Paramedic Regulators entry to practice exam has run virtually since May 2020 and has not been further impacted.
- June/July 2021- Pracitcal examinations are scheduled to resume on June 15, 2021 in Victoria, Vancouver, Vernon, Dawson Creek and Crankbrook with an accelerated examination schedule and added sessions to ensure all licensing candidates are offered an exam date by August 2021.
- June/July 2021 – Four special exam sessions for fire departments in North Vancouver, Port Moody, Terrace and West Kelowna have been approved to open examination spaces in the regular session locations.

**Licensing**

- March 25, 2020 - All student licenses were suspended as training program precepting was cancelled. Suspension of licenses is to ensure students have enough time remaining to complete training on their student licence once precepting resumes. A student licence may only be issued for a maximum of two years.
- March 30, 2020 - All EMAs with licenses expiring in April were offered a 60-day extension on their licence renewal requirements. This approach minimized administrative burdens on EMAs, while maintaining appropriate licensing requirements.
- April 8, 2020 - All EMA FRs expiring in May and June were offered a 6-month licence extension and those EMA FRs that accepted the 60-day extension for April were offered a further 4-month licence extension. A legal opinion advised that only EMA FR licences could be extended as the renewal requirement for EMR and above is less onerous than that of an EMA FR (application and payment versus two-hour online written exam and application).
- April 9, 2020 - Short-term licenses were available to all licence categories however, because of the delay in the May COPR exam sitting, some PCP short-term licenses were delayed. All candidates who completed their written and jurisprudence exams were offered a short-term licence for non-students, which may be issued and extended in 30-day increments for up to one year. 132 candidates were eligible for a short-term licence, and 12 were issued. Once the COPR results were received, 6 PCPs obtained a short-term licence.
- September 9, 2020 – All EMAs with a short-term licence for non-student were notified that because practical examinations have resumed, the short-term licences will no longer be renewed.
- January 22, 2021 – The short-term licence for non-students was again offered to all eligible candidates waiting for a practical examination.
- May 2021 – The short-term licence for non-students was extended until September 30, 2021 to ensure the applicants had time to complete the examination process. Short-term licenses continue to be offered to those candidates that have met the written and jurisprudence exam requirements and are waiting for the next available practical exam date.

**Continuing Competence**

- March 19, 2020 - the Director notified all EMAs that were required to report continuing competence that the requirements for the 2019/2020 reporting period (April 1, 2019 – March 31, 2020) would be waived. Of the 6,114 EMAs required to submit their continuing competence requirements, 2,233 were in shortfall and had their requirements waived.
- March 31, 2021 - Continuing competence requirements remained in place for the 2020/2021 reporting period (April 1, 2020 – March 31, 2021)
- May 7, 2021 - Shortfall notices were sent to 990 EMAs. There is no impact to licensure at this time and all EMAs that receive a shortfall notice have until June 15, 2021 to request an adjudication.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

June 2, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 2, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Emergency Medical Assistants Licensing Board/Branch

### TOPIC

The Emergency Medical Assistants Licensing Board is authorized under the *Emergency Health Services Act* to protect the public through the examination, registration and licensing of Emergency Medical Assistants (EMAs) in BC while setting terms and conditions for a licence and investigating complaints about EMAs. The EMA Licensing Branch supports the Board and is part of the Health Sector Workforce and Beneficiary Services Division in the Ministry of Health.

### CURRENT SITUATION

- Practical exams have been cancelled since April 26, 2021, and are set to resume June 15, 2021 on an accelerated schedule.
- In 2020/21, 656 practical exams where cancelled due to COVID and in 2021/22, 226 practical exams have been cancelled due to COVID. The Branch has developed an accelerated plan to address the backlog created by cancellations due to COVID-related travel restrictions by August 2021.

### KEY FACTS

- The Branch supports the Board by delivering key functions that include: recommending Board recognition of EMA training programs; developing and administering examinations that assess candidates' competency to practice; issuing and renewing licenses and maintaining the EMA registry; providing information to licence holders and stakeholders; and managing the Board's patient care complaint process.
- The Director of the Branch is appointed by the Minister to administer the annual continuing competence requirements set out in the EMA Regulation.
- The EMA Regulation defines 6 categories of licenses of EMAs in BC. As of April 29, 2021, there are 15,548 people holding valid EMA licences in BC.

| License Level | # of EMAs[1] |
|---|---|
| First Responder (EMA FR) | 7,835 |
| Emergency Medical Responder (EMR) | 2,445 |
| Primary Care Paramedic (PCP) | 4,478 |
| Advanced Care Paramedic (ACP) | 644 |
| Infant Transport Team (ITT) | 25 |
| Critical Care Paramedic (CCP) | 121 |
| Total EMAs in BC | 15,548 |

- The majority of EMAs are First Responders who are primarily firefighters. The remaining EMAs either work for BC Emergency Health Services (BC Ambulance Service) or are employed by private transport companies, industry, the military, or as instructors.
- The Board is comprised of three members appointed by Order-in-Council and must include one licensed EMA and one medical practitioner. The third appointee is the chair person. The chair Ryan Sinden, is a licensed EMA and Fire Fighter, the medical practitioner is Dr. Philip Yoon, and Grant Ross is the licensed EMA.
- The Branch conducts examinations as part of initial licensing, licence reinstatements, suspension removals, and continuing competence. Candidates are required to successfully complete written theory, jurisprudence and in some cases, practical examinations, in order to be licensed.
- All EMR and EMA FR written theory exams administered by the Branch are online. The training institution for CCP administers the CCP exams.
- All PCP and ACP initial licensing written exams are administered by the Canadian Organization of Paramedic Regulator's (COPR) Entry to Practice Examination. The COPR exam for PCP and ACP is a "national" exam used by seven jurisdictions in Canada (AB, BC, SK, MB, PEI, NL and NS).

[1] Source EMA Licensing Board Website http://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

- In December 2018, after a review of the decision to eliminate practical exams for the PCP and ACP licence categories, the Board decided that there was sufficient concern for patient safety to warrant reinstating the requirement for practical examinations for the PCP licence category. Practical examinations were fully implemented by April 1, 2020 for PCPs and April 1, 2021 for ACPs.

| Exam Type | 2019/20 Exams Conducted | 2020/21 Exams Conducted | 2021/22 YTD Exams Conducted |
|---|---|---|---|
| Practical Scenario | 1,356 | 1,582 | 356 |
| Practical Remedial Skill Test | 114 | 1 | 0 |
| COPR Entry to Practice Written Exam | 331 | 292 | 151 |
| Written Theory Examination Online | 872 | 837 | 175 |
| Jurisprudence exam | 1,413 | 1423 | 690 |
| EMA FR Licence Renewal Written Exam | 2,565 | 1926 | 263 |
| EMA FR Initial/Reinstatement Written Exam | n/a | 1191 | 280 |
| Total Exams Conducted | 6,651 | 7,252 | 1,915 |

- The Branch conducts practical examinations in Victoria, Vancouver, Vernon, Cranbrook and Dawson Creek. Evaluations are held at one of the five locations, based on a published schedule. Special exam sessions are held in rural/remote areas on an as needed basis.

| Practical Exam Locations | 2021/22 Scheduled Exam Sessions | 2021/22 Exam Sessions Cancelled due to COVID |
|---|---|---|
| Cranbrook | 3 | 1 |
| Dawson Creek | 3 | 2 |
| South Island (Victoria) | 9 | 3 |
| Vancouver | 6 | 2 |
| Vernon | 7 | 2 |
| Total Exam Sessions Scheduled | 28 | 10 |

- Applicants, or employers on their behalf, pay a licence fee of $50-$550 when examinations are required. These fees do not recover the full cost of providing examinations. No fees are charged for first responder initial licence or licence renewal exams, continuing competence exams, or for candidates seeking an endorsement[2].

Continued Regulation of EMAs under the *Emergency Health Services Act* (EHSA)

- Most health professions in BC are regulated under the *Health Professions Act.* EMAs are regulated separately under the EHSA. On April 4, 2019, the Ambulance Paramedics of BC (CUPE Local 873) wrote to the Minister in support of a regulatory college.
- In August 2020, the Steering Committee on Modernization of Health Professional Regulation released recommendations to the Minister for the modernization of the regulatory framework for health professions in BC. The recommendation for EMA regulation was, upon establishment of an oversite body, to prioritize review of EMAs and consider regulation under the *Health Professions Act*.

## FINANCIAL IMPLICATIONS

The Branch's net operating budget for 2020/21 was $1.41 million.

**Approved:**

June 2, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 3, 2021 – Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division
June 3, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

[2] http://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/colleges-boards-and-commissions/emergency-medical-assistants-licensing-board/licence-applications Accessed October 4, 2018

# LEGISLATIVE SESSION - FACT SHEET

## Extra Billing – *Canada Health Act*

### TOPIC

The *Canada Health Act* establishes criteria that 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 transfer payments to a province involved.

### CURRENT SITUATION

- Based on amounts of Extra Billing and User Charges (EBUC) reported by BC to Health Canada in its 2018/19 EBUC report (submitted in January 2021), BC's March 2021 Canada Health Transfer (CHT) payments were reduced by $13,949,979. Additionally, a $24,509,418 reimbursement was applied to BC's March 2021 CHT payments, which represents a partial reimbursement of BC's March 2019, March 2020, and March 2021 CHT deductions.
- On September 10, 2020, the BC Supreme Court ruled in the Province's favor in the Cambie Surgeries Corporation v. British Columbia (Attorney General) case.
- On December 8, 2020 the Court of Appeal issued a limited form of injunction which prohibits the Medical Services Commission 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* for any private surgeries where a patient has been scheduled for a date beyond 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 is in effect until June 18, 2021 or further order of the Court.
- This injunction will impact BC's ability to enforce all provisions of the *Medicare Protection Act*, which may lead to BC facing further federal health transfer deductions.

### KEY FACTS

- The BC Government is committed to upholding the principles of the *Canada Health Act* and to our publicly funded health care system, in which access to medically necessary services is based on a patient's clinical need rather than ability to pay.
- 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 2020 for 2018/19).
- Amounts reported by BC to Health Canada on extra billing and/or user charges, and corresponding federal deductions for prior years were:

| Fiscal Year | Reported Patient Charges | Result of Onsite Audits | Additional Health Canada Assessment* | Total |
|---|---|---|---|---|
| **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 |
| **2009/10** | $33,179 | | | $33,179 |
| **2008/09** | $75,136 | | | $75,136 |

* based on specific findings in the Cambie Surgery Centre

- Reported extra-billing has generally been associated with private surgical facilities or specialist consultation services.
- The Ministry of Health's Beneficiary and Diagnostic Services Branch follows up on all alleged cases of extra billing that are brought to its attention by writing to the physicians and clinics involved, requesting refunds to patients of any inappropriate charges. Unresolved cases are referred to the Medical Services Commission for further review and/or action.
- On average, the Beneficiary and Diagnostic Services Branch investigates approximately 12 cases of extra billing annually.
- In 2018/19 there were a total of 13 patients' complaints of which four were investigated. Nine cases were not formally investigated for a variety of reasons (e.g. the Ministry requested additional information from patient and patient never followed up, patient was seeking general information only, or the Ministry was unable to assist further due to the various forms of injunctions that existed throughout 2018/19).
- Beneficiary and Diagnostic Services Branch continues to work with legal counsel for the Province to determine next steps in relation to the December 2020 injunction and extra billing investigations.

## 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 health transfer payments.

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**Approved:**
June 1, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 3, 2021 – Marie Thelisma obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Facilities Bargaining Association Collective Agreement

### TOPIC

The Facilities Bargaining Association (FBA) and the Health Employers Association of BC (HEABC) 2019-2022 Collective Agreement.

### CURRENT SITUATION

Negotiations began on September 11, 2018 for a new agreement under the Sustainable Services Negotiating Mandate and a new three-year collective agreement was ratified on February 11, 2019.

### KEY FACTS

- The FBA collective agreement covers approximately 42,896 active employees, or 29,375 full time equivalents (FTEs), and represents an estimated $1.965 billion in annual compensation expenditure.[1]
- The Hospital Employees' Union (HEU) represents approximately 25,106 members, or 93% of the FBA FTEs.[2] The 10-union FBA includes members from the BC Government and Service Employees' Union.
- In January 2018, a standalone bargaining association was created for ambulance paramedics and dispatchers, which moved approximately 3,600 members out of the FBA into the Ambulance Paramedics and Ambulance Dispatchers Bargaining Association.
- Health care assistants represent the largest job classification in the FBA. Other job classifications include clerical positions, food service workers, trades and maintenance workers, lab assistants and nursing unit assistants.
- The average annual compensation (2018) for one health care assistant FTE is approximately $68,217 (including the cost of wages, benefits, and non-employee specific costs), or $34.98 per hour.[3]
- Facilities subsector employers pay 100% of the premiums for dental, extended health, group life and long-term disability insurance.

<u>COVID-19 Pandemic Single Site Order</u>

- As a result of COVID-19 outbreaks in long-term care and assisted living facilities, the Provincial Health Officer issued Single Site Orders, limiting the movement of staff between facilities.
- Facilities covered by the order includes long term care facilities, private and public hospitals, provincial mental health facilities and assisted living facilities.
- FBA health care workers working in a facility covered under the order are subject to the limitation to work at only one site.

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

A new 3-year collective agreement between the FBA and HEABC was ratified on February 11, 2019. Highlights of the facilities subsector agreement include:

- General wage increases of 2% annually in 2019, 2020, and 2021.
- Straight time paid hours calculated in 2017 to increase by at least 600,000 by December 31, 2021.
- A new domestic and sexual violence leave policy (up to 17 weeks unpaid leave).
- One-time funding of $1 million for the FBA education fund.
- Improved occupational health and safety language including data collection requirements and improved language mandating Code White incident reporting to the Joint Occupational Health and Safety Committee. Parallel language to improve reporting and prevention of workplace violence.
- New language regarding the implementation of Bill 47 including an agreement to assess the practicability of return of contracted services to the bargaining unit and direct control of the health authority.

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[1] PSEC. 2019. "Public Sector Compensation Annual Forecast 2019 (unreleased).", pg.33

[2] HEABC FBA Ratification Announcement, Retrieved on February 11, 2019 from http://www.heabc.bc.ca/public/News/2019/FBARatificationAnnouncement-Feb2019.pdf

[3] Facilities Subsector Fact Sheet, 2018 Estimates from http://www.heabc.bc.ca/public/Bargaining/2019/FactSheets/FactSheetFacilities-2018.pdf

- Establishment of a working group on recruitment and retention to address challenges in this area, with a focus on 'priority professions' identified by the Ministry of Health, including health care assistants.[4]
    - The committee for recruitment and retention was established in 2014 and reviewed in 2018. The committee last met on November 4, 2020 and includes a representative from the Ministry of Health. The Working Group has written recommendations for care aide recruitment and retention and has focused on priority occupations to support the surgical renewal strategy. In particular, the Ministry has consulted the Working Group on a government-led training and career laddering initiative for Medical Device Reprocessing Technicians.
- Creation of a steering committee on musculoskeletal injury prevention.
    - A Steering Committee on musculoskeletal injury prevention (MSI Prevention Project Steering Committee) was stood up on November 2, 2020, and last met on December 11, 2020. The Steering Committee is currently selecting four pilot sites to assess ergonomic concerns, create individualized interventions, and evaluate their outcomes.

## FINANCIAL IMPLICATIONS

The FBA collective agreement represents an estimated $1.965 billion in annual expenditure. A 1% negotiated increase represents approximately $19.7 million.[5]

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**Approved:**
January 25, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
February 8, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

[4] British Columbia Ministry of Health. 2018. "British Columbia Provincial Health Workforce Strategy 2018/19 – 2020/21". pg.19-20
[5] PSEC Compensation Annual Forecast, 2019 (unreleased), pg. 33

# LEGISLATIVE SESSION - FACT SHEET

## Fee-for-Service Temporary Changes for COVID-19 and Physician Payments

### TOPIC

Temporary fee changes to the Medical Services Commission Payment Schedule to support access to health services during the pandemic and fee-for-service (FFS) physician payments.

### CURRENT SITUATION

- There have been more than 50 temporary changes to the Payment Schedule, including the addition of 34 new fees, most with an end date to be determined by the Provincial Health Officer (PHO). Many of these fees parallel existing fees in the Payment Schedule but have fewer restrictions allowing broader access, including to virtual care in place of in-person care during the pandemic.
- FFS payments in March, April, and May 2020 were down 8.5%, 28.3%, and 24.2% respectively compared to the same periods in 2019.[1] Payments in September, November, and December 2020 were up 3.9%, 2.2%, and 3.7% respectively over the same periods in 2019. [2]

### KEY FACTS

- The Payment Schedule is the list of fees payable to enrolled physicians for insured medical services provided to beneficiaries enrolled with the Medical Services Plan (MSP).
- The Ministry of Health, in collaboration with the Doctors of BC (DoBC), the sections and the Joint Clinical Committees, made temporary changes to the Payment Schedule to support the Province's response to COVID-19, with the majority of the changes supporting greater access to telehealth services.
- The following temporary amendments to existing fees/billing rules were made to the Payment Schedule, with an end date to be determined by the PHO: (Effective date noted)
    - March 13, 2020 – the definition of "Telehealth Service" was amended to include the use of telephone and allow physicians to bill face-to-face fees for consultations, office visits and non-procedural interventions provided via telehealth where there is no telehealth fee available.
    - March 13, 2020 – the daily volume limit (DVL)[2] on office visits, counselling, and office complete examinations was suspended. The DVL was reinstated on October 1, 2020.
    - April 17, 2020 – suspend restrictions preventing radiologists from billing MSP for some remote readings.
- In addition, to support substance use risk mitigation, a permanent amendment was made to the Opioid Agonist Treatment Management fee effective July 23, 2020, to allow counselling and visit fees to be payable in addition to this fee, to compensate physicians when completing a more comprehensive review.
- The following new temporary fees were established, with an end date to be determined by the PHO (Effective date noted):
    - March 17, 2020 – 2 new office visit fees to recognize the additional effort and cost associated with testing and treating suspected/confirmed COVID-19 patients and track service utilization.
    - March 27, 2020 – 5 new fees to support provider-to-provider communication, facilitate simple prescription renewals and create additional physician capacity.
    - March 29, 2020 – a new perioperative complexity surcharge for surgeons, anesthesiologists and surgical assists for surgeries on patients with unknown or high risk of having COVID-19, to compensate for time to don/doff personal protective equipment and for the additional complexity.
    - April 15, 2020 – 2 additional specialist advice fees to further facilitate physician communication.
    - June 1, 2020 – 18 new family physician age-based telehealth office visit, counselling and consultation fees to mirror the face-to-face fees for these services. The existing telehealth fees (weighted average of the different age groups) were suspended.
    - October 1, 2020 – 2 new respiratory (influenza or pneumococcal) immunization fees for patients 19 or older. One fee may be billed at the same time as an unrelated, medically necessary visit and one fee is

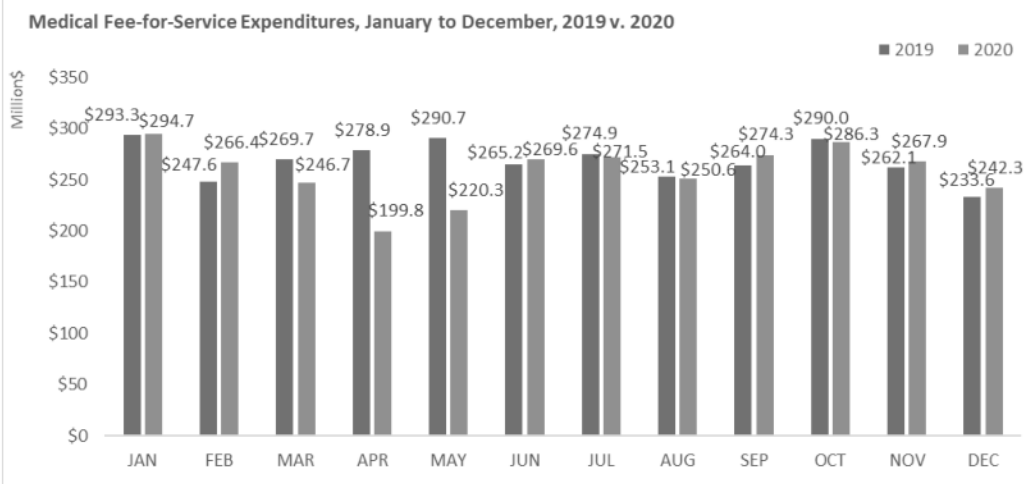
[1] Integrated Analytics, Primary & Acute Care and Sector Workforce; Health Sector Information, Analysis and Reporting Division. Ministry of Health. Data as of February 15, 2021 Paid Date. PAS 3000.1736

[2] Under the daily volume payment rules, when a physician bills more than 50 office visits, counselling visits, and/ or complete exams, the fee for these services is reduced by 50%. If they bill more than 65, they are not paid for the additional services.

for a stand alone immunization. The fees are no longer in effect as the pre-determined end date was April 30, 2021, to coincide with the end of influenza season.
  - January 25, 2021 – 3 new COVID immunization for a stand alone immunization, extended time on a stand alone immunization, and a fee that may be billed in addition to an unrelated visit.
  - April 15, 2021 – new Covid-19 Immunization Advice fee that may be billed in addition to an unrelated visit for when a physician provides advice on COVID vaccination but does not perform the immunization.
- Effective May 1, 2020, 130 telehealth fees were added to the list of fees eligible for the Business Cost Premium (BCP) to acknowledge many of the of the services being provided through telehealth during the pandemic would have likely otherwise been provided in person and physicians are still paying overhead on the facilities where they would have been delivered. Four additional fees were added to the list on December 1, 2020 and another 6 were added April 1, 2021.
- Pursuant to the 2019 Physician Master Agreement, the BCP was implemented April 1, 2020, and has a defined budget allocation for 2020/21 and 2021/22.
- Given the urgency of the pandemic, these changes/fees were implemented via an expedited process with the DoBC. Appropriate stakeholders were consulted, the DOBC and Ministry agreed on the details, and the Office of the PHO approved the proposed changes.
- The BC Centre for Substance Use (BCCSU) published pandemic prescribing guidelines for physicians treating patients with opioid use disorder during the pandemic. The Ministry is working with the Ministry of Mental Health and Addictions, BCCSU, BC Family Doctors and DoBC to ensure appropriate payment for this service.

**Fee-for Service Payments (January to December)**

Payments in March, April, and May 2020 were down 8.5%, 28.3%, and 24.2% respectively compared to the same periods last year.[3] Payments in September, November, and December 2020 were up 3.9%, 2.2%, and 3.7% respectively over the same periods in 2019.




## FINANCIAL IMPLICATIONS

MSP data indicates that the total FFS payments to physicians were $3.09 billion in the calendar year 2020 compared to $3.22 billion in the calendar year 2019. The drop was $132.36 million or 4.1%.

**Approved:**

February 20, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
April 6, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division
April 7, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
June 10, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[3] Integrated Analytics, Primary & Acute Care and Sector Workforce; Health Sector Information, Analysis and Reporting Division. Ministry of Health. Data as of February 15, 2021 Paid Date. PAS 3000.1736. Note that expenditures include GPSC and SSC fee items.

# LEGISLATIVE SESSION - FACT SHEET

## Gender-Affirming Surgery

### TOPIC

Gender-affirming surgeries are relatively recent additions to the Medical Services Plan (MSP) Payment Schedule. A history of these procedures within the Payment Schedule is provided below.

### CURRENT SITUATION

- MSP covers the following upper gender affirming surgeries (UGAS):
  - Bilateral breast construction in the context of gender affirming surgery, male to female (MtF) (61053), valued at $772.73.
  - Bilateral mastectomy in the context of gender affirming surgery, female to male (FtM) (61054), valued at $1,476.26.
- MSP requires patients to obtain prior approval before gender-affirming surgery is considered to be a benefit. A medical assessment must be completed by a qualified assessor with recognized expertise in the treatment of gender dysphoria.
- Eligibility criteria for gender-affirming surgery requires the patient to reach the age of majority. However, upper surgery is sometimes performed before the patient is 18 years old. Additional assessments are required to approve these procedures for minors.
- The number of services for UGAS billed to MSP has increased annually from 1 in 2013/14 to 368 in 2019/20, for a total of 1,352 services and a total paid amount of $1.96 million[1] to date. Of these, 1,315 were female to male procedures, and 37 were male to female.
- Lower gender affirming surgeries (LGAS) are funded through Provincial Health Services.

### KEY FACTS

In B.C. approximately 46,000 people identify as trans or gender diverse. Only a small portion of this population will access medical or surgical services for gender affirmation.[2]

**Upper Gender-Affirming Surgeries (UGAS)**

- MSP implemented two UGAS fees (61054 and 61053) in 2010/11 and 2019/20 respectively. No claims for 61054 were received until 2013/14.

**Table 1: Medical Services Plan payments for Gender Affirming Surgeries, fiscal year 2013/14 to 2020/21**[3]

| Fiscal | Fee Item | Fee Description | Services | Paid Amount |
|---|---|---|---|---|
| 2013/2014 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 1 | $1,447.82 |
| 2014/2015 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 4 | $5,817.24 |
| 2015/2016 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 25 | $36,293.30 |
| 2016/2017 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 78 | $113,499.60 |
| 2017/2018 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 122 | $178,155.58 |
| 2018/2019 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 152 | $223,215.59 |
| 2019/2020 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 359 | $529,977.34 |
| 2020/2021 | 61054 | Mastectomy-Gender Affirming, FTM-Bilateral | 574 | $847,373.24 |
| | | **Total for 61054** | **1,315** | **$1,935,779.71** |
| 2019/2020 | 61053 | Breast Construction, Gender Affirming, MTF-Bilat | 9 | $6,954.57 |
| 2020/2021 | 61053 | Breast Construction, Gender Affirming, MTF-Bilat | 28 | $21,636.44 |
| | | **Total for 61053** | **37** | **$28,591.01** |

- UGAS procedures were performed in BC prior to the implementation of these fees but they were billed using the fees for cisgender breast augmentation and/or mastectomy. Some physicians may still be billing for UGAS using cisgender fees.

[1] Ministry of Health Medical Services Plan database, Current to paid date May15, 2021 (PAS 3000.2205).
[2] *Provincial Health Services Authority, http://phsa.ca (accessed September 10, 2020)*
[3] Ministry of Health Medical Services Plan database, Current to paid date May 15, 2021 (PAS 3000.2205).

# LEGISLATIVE SESSION - FACT SHEET

**Lower Gender-Affirming Surgeries**

- Until recently, approved LGAS were performed either out-of-province or out-of-country due to the lack of suitably trained surgeons in BC.
- In the fall of 2018, the Ministry of Health, in concert with the Provincial Health Services Authority (PHSA) and Vancouver Coastal Health Authority (VCHA) reached agreement to ensure LGAS could be provided in BC.
- These procedures are now funded through VCHA's Gender Surgery Program BC in VCH. Physician funding is provided through the Ministry's Alternate Payments Program (APP).
- To support monitoring and reporting on these specialized procedures, MSP implemented a number of new zero-dollar encounter codes in February 2020.
- Annual volumes of surgeries are reported by VCH as follows:

| **2019/20** | | | **2020/21** | | | **2021/22 (*as of 2021-04-30*)** | | |
|---|---|---|---|---|---|---|---|---|
| New Surgeries | Revisions | ***Total Surgeries*** | New Surgeries | Revisions | ***Total Surgeries*** | New Surgeries | Revisions | ***Total Surgeries*** |
| 7 | 39 | ***46*** | 50 | 26 | ***76*** | 4 | 1 | ***5*** |

## FINANCIAL IMPLICATIONS

- MSP fees are demand driven. Expenditures for fee item 61054 have increased significantly every year since the fee was implemented in 2013/14 (see table 1).
- The Ministry's APP program has 3.0 FTEs in contract funding allocated for the Gender Surgery Program. The program currently has contracted capacity for 2.0 FTEs of clinical service (valued at $1.089 million in 2021/22).
- Starting in 2019/20, annual base funding of $2.6 million has been provided to PHSA to support Lower Surgeries.

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**Approved:**

May 21, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 1, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
June 8, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Group Contract for Practicing Full-Service Family Physicians

### TOPIC

- In support of the Primary Care strategy, in fall 2019 the Ministry of Health introduced a new group contract for full-service practicing family physicians (FPs) who have an established patient panel.
- The contract provides compensation to physicians based on their hours worked, the number and complexity of their attached patients, and participation in Quality Improvement (QI) activities. The contracts will be offered to clinics who are participating in or who will commit to actively support the implementation of a Primary Care Network (PCN) in their community.

### CURRENT SITUATION

- In 2018, the Ministry developed a contract for new-to-practice FPs without established patient panels, with the goal of increasing patient attachment across PCNs. At that time, the Ministry committed to developing a contract for physicians with established panels.
- The 2019 Physician Master Agreement (PMA) outlines the consultation process between the Ministry and the Doctors of BC for new physician compensation models.
- Consultations with the Doctors of BC began in September 2019 and concluded in July 2020.
- The Ministry introduced the contract on October 2, 2020, and the Doctors of BC posted information on their website On November 9, 2020, the Ministry opened the expression of interest (EOI) process through a staged approach.
- In the first stage, Expression of Interest forms are being accepted from physician groups in PCN communities with approved plans and implementation underway. The second stage will include communities in final stages of PCN planning, and the third stage will accept EOIs from all communities. The EOI process is currently in the first stage.

### KEY FACTS

- As of May 18, 2021, 42 EOIs have been received (14 in VCHA, 10 in FHA, 6 in IHA and 12 in VIHA), of which, 2 are out of scope for the first stage of the process and 4 EOIs do not meet eligibility criteria[1].
- 36 assessments have been completed or are underway. Of these 36, the clinic's funding assessment results have been provided to 21 clinics. The Ministry is undertaking additional analyses and policy work on the remaining 15 clinics.
- The Ministry and regional health authorities are working towards onboarding the first 2 contract clinics on July 1, 2021.
- The contract is targeted towards groups of practicing FPs with established patient panels who work together in a group practice to provide community-based longitudinal care to patients.
- The contract is available to all eligible FPs in BC who want to transition off of the Fee-For-Service (FFS) payment model. Compared to FFS, the contract better supports team-based care and the attributes of the Patient Medical Home (PMH).
- The physician group signs a contract which is administered by the health authority, with support from the Ministry of Health. Payments under the contract are made at the clinic level.
- The initial term of the contract is 3 years.
- The contract contains the following expectations and obligations:
    - Participation in the local PCN and adoption of the attributes of the PMH.
    - Participation in ongoing Quality Improvement (QI) initiatives and activities.
    - Provision of longitudinal, full-scope primary care services to a panel of patients, with panel size expectations commensurate with the overall complexity of the panel.
- 1.0 Full Time Equivalent (FTE) of Services is defined in the contract as 1,680 to 2,100 direct or indirect patient care, or clinical administration hours annually.

[1] Note: refers to clinics who applied with fewer than three physicians.

- The contract contains 3 distinct payment streams:
    - Hours-based payment: A base rate of $269,664 annually per FTE, with yearly increases in alignment with the PMA.
    - Panel size/complexity premium: Up to an additional $40,000 annually per FTE (available in $10,000 increments) based on the size and complexity of the patient panel.
    - QI payment: Up to $20,000 annually per FTE based on participation in and completion of mandatory and optional QI activities offered through GPSC.
- Additional contract requirements:
    - Intra-group agreement between the physicians which governs their relationship.
    - Teleplan reporting: shift and service-level information.
    - Health authority reporting: hours worked under the contract.

## FINANCIAL IMPLICATIONS

Financial implications are not yet known as uptake on the contract is yet to be determined.

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**Approved:**
May 21, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services

# LEGISLATIVE SESSION - FACT SHEET

## Health Care Assistant Dual Credit Programs

### TOPIC

Ministry of Health (MoH) has been working on determining the feasibility, scope and criteria to spread the existing health care assistant (HCA) high school dual credit (DC) programs across BC to support recruitment initiatives under MOHs HCA Education, Recruitment and Retention Strategy, i.e., HCA Strategy.

### CURRENT SITUATION

Further consultations with MoH, the Ministry of Advanced Education and Skills Training (AEST) and system partners will be required to assess the feasibility of the sustainability of HCA DC programs.

### KEY FACTS

- In 2018, under MoH's HCA Strategy, HCA DC programs were a proposed (unapproved) initiative (phase II) to support the development and sustainability of the HCA workforce. Dual credit programs enable high school students with a minimum of Grade 10 education to take post-secondary institution (PSI) courses tuition free while completing high school education.
- In 2017/18, 3,500 Grade 11/12 students (3.05%) enrolled in a variety of DC courses at BC PSIs, including HCA and non-HCA courses. [1] DC courses are funded by course like all other courses in Grades 10 – 12. The Ministry of Education (EDUC) completed a review of the K-12 funding model in 2018, with further engagement on implementation in 2019. In February 2020 a 2-phase implementation approach was announced with the first phase focussed on policy alignment, financial management and accountability recommendations. The funding model review panel report has recommended that funding for Grades 10 -12 courses move from a course-based model to a headcount-based model and that unique student needs be funded using population-based data[2].
- EDUC believes there is positive potential for this to provide more flexibility for school districts to determine types of programs for DC. In Canada, BC[3], Alberta (AB)[4], Saskatchewan (SK)[5], Manitoba[6], and Ontario (ON)[7] have established direct support for provincial implementation of DC.[8]
- Support for career pathway has been identified as an aim for DC programs by several BC PSIs.[9]
- **BC HCA DC Programs:** Nine PSIs in BC are delivering HCA DC programs*[10]:

| Institution | FTEs | Graduates | Institution | FTEs | Graduates | Institution | FTEs | Graduates |
|---|---|---|---|---|---|---|---|---|
| **Camosun College** | 6-9 | 54 (2011-19) | **Coast Mountain College** | 3 | 0 (April 2018-June 2019) | **Okanagan College** | 4-5 | 5 (Spring 2018-Spring 2019) |
| **North Island College** | 3 | 1 | **Northern Lights College** | 2-3 | 5 (2015); 1 per year (2017-19) | **Selkirk College** | 3 | 3 |
| **Thompson Rivers University** | 10-16 | 100% grad rate (last 3 years) | **Vancouver Community College** | 4 | 100% grad rate | **Vancouver Island University** | 20 | Unknown |

*Most programs range from one to three intakes per year.

[1] Email correspondence from AEST to Nursing Policy Secretariat, no updates, January 18, 2021.
[2] Email from EDUC to NPS January 20, 2021.
[3] BC Ministry of Education https://www2.gov.bc.ca/gov/content/education-training/k-12/administration/legislation-policy/public-schools/recognition-of-post-secondary-transition-programs-for-funding-purposes accessed January 16, 2020.
[4] Government of Alberta https://education.alberta.ca/media/3704363/alberta-dual-credit-framework-november-2017.pdf
[5] Saskatchewan Ministry of Education https://pubsaskdev.blob.core.windows.net/pubsask-prod/82846/Dual%252BCredit%252BPolicy.pdf accessed January 15, 2020.
[6] Government of Manitoba https://www.edu.gov.mb.ca/k12/policy/gradreq/docs/dc_policy_17.pdf accessed Jan. 16, 2020.
[7] Ontario Ministry of Education http://www.edu.gov.on.ca/eng/teachers/studentsuccess/DualCreditPro.pdf accessed Jan. 16, 2020.
[8] Alberta Govt https://education.alberta.ca/media/3704363/alberta-dual-credit-framework-november-2017.pdf p. 4., accessed Jan. 16, 2020.
[9] BC Council on Admissions & Transfer, Dual Credit: Secondary to Post-Secondary Transitions: Dual Credit Policy and Practice in BC and Elsewhere, p.l9 http://www.bccat.ca/pubs/dualcredit_report.pdf March 2015, accessed September 27, 2019.
[10] Data from AEST, August 2019. NPS confirmed no updates January 18, 2021 . August 2019 is the most current data available.

- Establishing and expanding HCA DC programs has been an initiative recommended by the BC Care Providers Association to the Ministry to address recruitment challenges in continuing care.[11]
- Dual credit has been viewed as a recruitment strategy by some post-secondary institutions (PSIs), as it helps enable smooth transitions for students from high school to PSI and to the workforce.[12]

**Example of BC HCA Dual Credit Program – South Island Partnership (SIP) Case Study** [13]

- Camosun College (CC) offers a HCA dual credit program through the SIP. Tuition costs are paid by the DC student's school district, funding is provided by EDUC. CC DC students are exempt from student ancillary fees but pay application fee and costs for textbooks, supplies, or personal safety equipment.
- CC DC students can take courses or programs in a defined DC "Transition Program," if they possess the appropriate prerequisites. DC Transition Programs include secondary and post-secondary courses or programs in a specific field of study. CC offers transition program pathways in communication, business, health, trades and technology. Students in the CC HCA Dual Credit program take 12 post-secondary courses and most HCAs in the CC DC program have been hired upon graduation.
- Other Provinces HCA DC Programs: AB (Norquest, Bow Valley College, Northern Lakes) and ON's **Canadore** College have HCA DC program PSI public facing information. [14] AB, SK and Nova Scotia have confirmed they are currently delivering HCA DC programs.[15] There are 16 HCA DC programs being offered in AB delivered by six PSIs.[16]

**Issues**

- Evaluation of DC programs in BC have identified issues include funding, equity in access, standards, articulation, and communications with the public regarding the availability of programs. The analysis noted challenges with communications across the sectors, awareness of policies and programs and understanding of the benefits of DC.[17] In the evaluation, many institutions noted the need for coordinators or a designated liaison person at the school and district level, as well as at the PSI.[18]
- Evaluations and anecdotal feedback have noted maturity levels of high school students and their commitment to DC programs as another key issue.[19] Education partners note that appropriate levels of preparation and maturity are critical for the role, and important for HCA DC programs due to the vulnerable populations they will be caring for.[20]
- Funding for DC programs is raised as an issue, as there are many variables involved including the block funding system, numbers of enrollees, the FTE funding rate and program type.[21]
- Operational challenges identified include timetabling, scheduling, term lengths, and reporting dates. Evaluations found that misalignment of yearly and daily schedules of high schools and PSIs was the most common issue.[22]

## FINANCIAL IMPLICATIONS

Financial implications for MoH in expanding HCA DC programs will require further consultation with AEST and system partners to further explore feasibility of program expansion. The HCA strategy proposed DC initiative is under consideration and review: no funding source has been identified at this time.

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**Approved:**
January 26, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

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[11] BC Care Providers Association, June 2018, Situation Critical: A Made-In-BC Plan to Address the Seniors Care Labour Shortage https://bccare.ca/wp-content/uploads/2018/10/Situation-Critical-July-2018-updated.pdf accessed Oct. 1, 2019.
[12] BC Council on Admissions & Transfer, Dual Credit Programs: Exploring dual Credit Student Transition and Post-Secondary Academic Success, p. 1, May 2017, https://www.bccat.ca/pubs/dualcredit_may2017.pdfhttps://www.bccat.ca/pubs/Reports/DualCreditPrograms2017.pdf accessed Sept. 27, 2019.
[13] BCCAT, Dual Credit Programs 2017, Camosun College-South Island Partnership Case Study, p. 1., accessed Sept. 27, 2019.
[14] Internet Scan HCA DC Programs of Other Canadian Jurisdictions, Completed Nov 5, 2019, NPS.
[15] Jurisdictional scan of HCA DC programs, completed March 2020, NPS.
[16] Initial data received as of February 2020. Alberta Education Curriculum Division confirmed no 2021 updates at this time January 20, 2021.
[17] BCCAT, Secondary to Post-Secondary Transitions, March 2015, p. 21.
[18] Ibid.
[19] Ibid.
[20] Ministry of Health Labour Market Analysis Session and Consultations, June 29, 2017.
[21] BCCAT, Secondary to Post-Secondary Transitions, March 2015, p. 22.
[22] Ibid.

# LEGISLATIVE SESSION - FACT SHEET

## Health Care Assistant Expedited Registration Pathway

### TOPIC

The Ministry of Health (MoH) developed the Expedited Registration Pathway (pathway) for Canadian Out of Province (OOP) Health Care Assistants (HCA) (trained in Canada, outside of BC) to address current registration barriers, support employers in hiring qualified HCAs and increase HCA supply.

### CURRENT SITUATION

- The pathway policy was announced by the Minister of Health on November 13, 2019 and implemented on January 15, 2020. The pathway is not mandatory for BC publicly funded employers. Employers who sign up for the pathway are called Participating Employers.
- The objective of the pathway is to ensure an effective, efficient registration pathway for qualified OOP HCAs/equivalent workers, and creates a shared accountability between the Participating Employer and BC Care Aide & Community Health Worker Registry for ensuring the competency of qualified Canadian HCAs before they provide patient care.

### KEY FACTS

- The Registry confirms the applicants' credentials meet the pathway's minimum standards.
- Participating Employers must ensure the qualified Canadian HCA employee completes a standardized orientation program and is competent to deliver safe/effective care.
- Publicly funded employers choosing to not participate in the policy are only permitted to hire HCAs who are already registered with the Registry.
- This new pathway streamlines registration processes and has shown to increase registration of HCAs (310 applicants in total have been registered via the Expedited Pathway since it was implemented)[1] helping to meet labour demand and delivery of services to seniors.

**Registry Qualification Requirements**

- As part of the Registry application process – HCA applicants provide practice hours documentation (former employer), proof of graduation from a recognized Canadian HCA education program, English language proficiency, chronological resume, and competency reference letter(s).
- The Registry provides approved HCAs with a Letter of Eligibility, which in turn the HCA provides to the Participating Employers as step one in the hiring process.

**Participating Employer Pathway Process Requirements**

- There was consensus from the Nursing Policy Secretariat (NPS), the Registry and health authorities (HAs) on the content for the standardized orientation pathway.
- After applying for employment, the HCA is issued an employment letter and must successfully complete the orientation program in one month and become Registered before being able to provide care.
- BC Participating Employers and their HCA employees hired via this pathway will have access to the LearningHub's course content to meet the policy's required theory component.
- The content of the standardized orientation program (theory) is hosted on the Provincial Health Services Authority's (PHSA) online LearningHub site and includes topic areas: Violence Prevention, Infection Prevention, Safe Patient Handling, and Recognizing and Reporting Adult Abuse. This component takes approximately 7 hours to complete.
- In addition to the theory content, an additional 4 hours (approximately) of skills/return demonstration is required to assess the competencies for Infection Prevention and Safe Patient Handling modules.
- HCAs must also complete the Health Care Assistant Practice in BC course (approx. 5 hours), offered online via the PHSA LearningHub.

[1] Data received from the BC Care Aide & Community Health Registry as of May 31, 2021.

- Once the HCA completes the standardized orientation program, the Participating Employer has one week to provide a verification notice to the Registry.
- The Registry, within 3 – 5 business days, will register and notify the HCA that a registration number has been assigned. The HCA will inform the employer, who must also check that the number is valid, and then the HCA employee is able to provide care.

**Nursing Community Assessment Service (NCAS) Competency Assessment Pathway** (See NCAS Fact Sheet)

- The new expedited pathway is **not** open to Internationally Educated Health Professionals as there are no internationally universal nursing programs with common, consistent curricula, competencies and practice standards; this necessitates Canadian nursing regulators to develop assessment processes to determine equivalencies within their provincial/ territorial jurisdictions. NCAS functions as part of this assessment process.
- The Internationally Educated Nurses (IENs) pathway to nursing (HCA) requires them to first have their credentials assessed by the National Nursing Assessment Service (NNAS). Once their credentials are approved by NNAS, the IEN must apply for licensure to the BC College of Nursing Professionals (BCCNP). BCCNP refers IENs to NCAS for a competency assessment (See IEN Fact Sheet)
- It is expected that a number of Canadian OOP HCA applicants will not meet all of the requirements for the new Expedited Registration Pathway, however, they may still qualify for the NCAS competency assessment pathway.

**Current Process due to COVID-19**

- On March 26, 2020, due to the COVID-19 pandemic, the pathway was temporarily revised to further streamline the registration process.
- The intention was to further expedite hiring of HCAs, so HCAs were employment-ready before hire, by removing Participating Employer involvement in the pathway process, and instead requiring eligible applicants to complete a free/easily accessible online Standardized HCA Orientation Program prior to registration on the Registry.
- This process has been put in place as a temporary measure to support health human resources needs during the COVID crisis and has been extended for the duration of the COVID pandemic. The MoH will conduct a thorough evaluation of this revised pathway.

## FINANCIAL IMPLICATIONS

In 2018/19 the Ministry allocated $555,000 over 3 years to support HCA Registration and Career Pathway Support.

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**Approved:**

February 7, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
February 9, 2021 – Ian Rongve, ADM, COVID Response & Health Emergency Management Division
June 10, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Care Assistant Oversight

### TOPIC

- The Health Care Assistant (HCA) occupation is unregulated in BC. Oversight is provided by employers and the BC Care Aide & Community Health Worker Registry. 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.
- The Registry has limited ability to fulfill its mandate due to lack of regulatory authority, including inability to require private employer participation.

### CURRENT SITUATION

Advice/Recommentations

### KEY FACTS

- In response to elder abuse incidents that received widespread public attention, the Registry was established in 2010. It was created through a "Letter of Understanding" signed by the Health Employers Association of BC, the Facilities Bargaining Association, and the Community Bargaining Association. The Registry has no authority under legislation or regulation.
- Health employers receiving public funding, including private employers under public contract, are required to employ HCAs who are active registrants of the Registry, and report to the Registry every suspension or termination for alleged client, patient and/or resident abuse. Private employers who receive no public funds are not required to participate, but HCAs working for these employers who meet the Registry's eligibility requirements are permitted to register.
- Individuals registered on the Registry work in a variety of settings, including but not limited to Home and Community Care (home care, assisted living residences, and residential care facilities) and Acute Care, and have a wide variety of job titles depending on their employer(s).
- 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.
- BC has seen a number of successes with the Registry model, including the development and implementation of education recognition processes for HCA programs in BC. However, concerns regarding the Registry's ability to fulfill the patient protection mandate surfaced from several sources, including the BC Ombudsperson's 2012 report, a 2013 external review of the Registry model, and the BC Seniors Advocate. The most significant gap in patient safety identified by the Ombudsperson and the 2013 external review was the Registry mandate extends only to HCAs working for publicly funded health employers.
- Recommendations from the 2013 review covered 4 areas: 1) broadening the enabling framework to include privately funded organizations; 2) strengthening the governance structure; 3) addressing gaps in the protection mandate; and 4) reviewing the funding model. In response, the Ministry created an Action Plan, covering short, mid, and long term goals for improving the areas identified in the review recommendations. Progress on the goals includes:
  - An assessment of private health care organizations that employ HCAs was completed in Spring 2014. The final report includes information on number and type of private employers, feasibility of mandating private employer participation, and potential mechanisms for a mandate.
  - The feasibility of moving the criminal records check process to the Registry has been assessed. Advice/Reco
    Advice/Recommentations

    Advice/Recommentations at this time, the criminal record check process remains the responsibility of the employer as determined by existing legislation.
  - Written procedural standards for the Registry's investigative processes have been established.

- The educational recognition processes comprise a critical component of the Registry's quality assurance and protection mandate by ensuring that registered HCAs possess the knowledge and skills to provide proper care. The Registry maintains a list of recognized BC HCA programs on its website. The Registry notes that employers should confirm education credentials and recent work experience prior to hiring applicants who are registered HCAs. The Registry was implemented in a phased approach, and not all registrants hold a relevant education credential and/or have recent work experience.[1] New Registry applicants must hold a relevant education certificate.

- The Ministry's competency profile was updated in 2014 and informed a 2015 curriculum update. Changes in the 2015 curriculum reflected the evolving role of HCAs, including their growing presence in acute settings, as well as an increased focus on Aboriginal health, dementia care, communication skills and abuse reduction.

Advice/Recommentations

- In 2015, input was obtained from stakeholders on how best to proceed with enhanced oversight for these health care workers.Advice/Recommentations

Advice/Recommentations All stakeholders consulted expressed support for the Ministry's interest in enhancing the oversight model for HCAs.

- In 2016, the Ministry published an HCA Oversight Policy Intentions Paper for consultation. This paper proposed an approach to regulate HCAs through a new registry model, to address critical gaps in the current oversight model and enhance patient safety.Cabinet Confidences; Advice/Recommentations

Cabinet Confidences; Advice/Recommentations

- The existing Registry is continuing business operations as usual in the interim.
- As of October 10, 2019, a long-standing Registry requirement that individuals reside in BC before applying for registration is no longer in effect. This change enables the submission of applications and processing of registrations for applicants residing outside of BC.
- As of April 1, 2021, 38,596 HCAs are registered with a status of 'active-good standing.'[2]
- From the Registry's inception in 2010 to April 1, 2021, 906 alleged abuse reports have been received from employers, with all reported HCAs immediately suspended from the Registry. Of those reported, 478 received temporary suspensions, and 428 were terminated by their employers. Of the 428 employer terminations: 158 HCAs were removed from the Registry uncontested, and 43 were returned to the Registry by mutual agreement between employer and union without investigation. Investigations were initiated for 227. Of the 227 investigations, 222 have been completed, with 36 HCAs de-registered, 122 re-registered with conditions, and 64 re-registered where no abuse was attributed to the employee. There are 5 active investigations.[3]

## FINANCIAL IMPLICATIONS

A budget of $600,000[4] was allocated for the operating costs of the Registry for Fiscal 2020/21.

**Approved:**

June 1, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services

June 3, 2021 – Brenda Rafter Executive Director obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] BC Care Aide & Community Health Worker Registry website, retrieved June 4, 2020 from https://www.cachwr.bc.ca/About-the-Registry.aspx

[2] BC Care Aide & Community Health Worker Registry Spring 2021Update Report, May 27, 2021

[3] BC Care Aide & Community Health Worker Registry Spring 2021 Update Report, May 27, 2021

[4] Fiscal 2020/21 Shared Cost Arrangement #2018-001, Modification Agreement #3, with Health Employers Association/Health Match BC Also see HEABC Funding letter.

# LEGISLATIVE SESSION - FACT SHEET

## Health Care Assistant Workforce Strategies

### TOPIC

The Ministry of Health (MoH) has financially invested in supporting the development and sustainability of the Health Care Assistant (HCA) workforce.

### CURRENT SITUATION

- In 2017 MoH approved 3 initiatives to meet the growing demand of the HCA labour force (for full details/financial breakdown see supplemental document "HCA Supplement Estimates January 2021"):[1]
    1) Investment in training capacity
    2) HCA Conversion (casual/part-time to FTE)
    3) Provincial Marketing and recruitment Campaign
- In November 2019 the Minister announced and implemented the HCA Expedited Registration Pathway for Canadian out of province HCAs (for more information see "HCA Expedited Pathway Fact Sheet").
- In September 2020 the Minister of Health announced the Health Career Access Program (HCAP). This program has been created to address the shortage of health care workers in long-term care and assisted living facilities, which has been exacerbated due to COVID-19 pandemic (for more information see "Health Careers Access Program Fact Sheet").

### KEY FACTS

- HCAs provide personal care assistance and services in a variety of health care settings: long term care (LTC), assisted living, group homes, community and acute care hospitals.
- The HCA workforce is estimated to expand by an average of 2.1 to 2.4% annually, with a 5-year gap of 1,928 (net new based on head count, not FTE) – FY 2019/20-2023/24 (all settings i.e. residential, community, and acute, excluding privates). [2]
- As of January 2021, there are 18 public institutions, 20 private institutions, 1 school district program in BC offering the provincially recognized HCA curriculum.[3] The total seats funded at public institutions in 2020/21 is 1,380 publicly funded seats (this includes one-time funded seats). The ongoing target is 1,038.[4]
- Since 2017, there have been a total of 574 HCAs registered after completion of NCAS HCA competency assessment.[5]
- The BC Care Aide & Community Health Worker Registry (Registry) recognizes both public/private programs.[6] The Registry reviewed and approved 19 one-time funded HCA programs by recognized education institutions for delivery in 2020.[7]
- HCA programs are typically 8 months (with an additional 12 weeks for programs offering an HCA ESL variation). On average, BC HCA programs offer 2 intakes per year.[8]
- In 2017 MoH approved 3 strategies to meet the growing demand of the HCA labour force (for additional detail refer to HCA Strategy Supplement Documents);
    1) Investment in HCA training capacity - Investment in HCA Training Capacity of 383 net new, one-time additional training spaces for 2018/19, 2019/20, and 2020/21: MoH: 300 seats; Ministry of Advanced Education and Skills Training (AEST): 83 seats)[9]
    2) HCA Conversion (casual and part-time to FTE) - Conversion of Casual/Part-time Positions to FTE of 10% casual/part-time positions to FTE in health authority and contracted facilities, where there is a demonstrated need with a 3-year net gain estimated at ≈500 FTEs (net new). In 2017 MoH committed to

[1] Cliff# 1115957 BN, Advancing HCAs Education, Recruitment and Retention, Signed by the DM on Sept 18, 2018.
[2] Data received from HSIAR, January 18, 2021.
[3] Data received from BC Care Aide & CHW Registry January 15, 2021.
[4] Data received from AEST, January 18, 2021.
[5] Data received from the BC Care Aide & Community Health Worker Registry, January 18, 2021.
[6] BC Care Aide & CHW Registry, https://www.cachwr.bc.ca/About-the-Registry/List-of-HCA-programs-in-BC.aspx.
[7] Data received from BC Care Aide & CHW Registry January 15, 2021.
[8] Report received through email correspondence from the BC Care Aide & Community Health Worker Registry, November 30, 2017.
[9] Note: there is discrepancy between the 383 seats in the BN, and the funding announcement of 384. AEST states number of seats can change due to several issues, such as planned vs implemented seats.

meet a minimum of 3.36 direct care hours per resident day (an equivalent to roughly 900 net new HCAs FTEs over 3 years).[10] In September 2018, the Premier's office announced 330 HCA FTE conversions in 2017/18, with another 500 in 2018/19.[11] However, with the implementation of single-site protocols due to COVID-19, this initiative is no longer relevant.

3) Provincial Marketing and Recruitment Strategy - Campaign implemented in 2019 in collaboration with the Health Employers Association of BC, BC College of Nurses and Midwives and Health Match BC to generate an estimated 200 net new HCAs in 3 years.

- In November 2019 the Minister announced and implemented the HCA Expedited Registration Pathway for Canadian out of province HCAs. This pathway ensures the effective, efficient registration for qualified OOP HCAs/equivalent workers. On March 26, 2020, due to the COVID-19 pandemic, the pathway was temporarily revised to further streamline the registration process (See Fact Sheet HCA Expedited Pathway).
- In an effort to support LTC staffing needs due to COVID-19 during the winter months the MoH initiated a pilot with the Registry to expedite registration of internationally educated individuals, who have been assessed with very few undemonstrated competencies, to become HCAs. For the pilot individuals received provincial orientation curriculum to enable them to address knowledge gaps. To date, 14 out of the original pilot group of 17 have been successfully registered (82%).[12]
- In September 2020 the Minister of Health announced the Health Career Access Program (HCAP). This program will provide opportunity to recruit an estimated 7,000 health-care workers in long-term care homes and assisted-living facilities and 3,000 in home health (community care) throughout the province providing a path for approximately 3,000 (net new) Health Care Support Worker (HCSW) positions.
- Post secondary institutions have developed 2 model frameworks for the HCA-PP (Health Care Support Workers enrolled in the HCAP program). A part-time modular model where students split their weekly time between work periods and the HCA education program, and a block modular model where students undertake alternating work periods and education program modules.

## FINANCIAL IMPLICATIONS

- MoH provided $2.5 million to AEST in 2017/18, 2018/19 ($5 million) to support HCA training (funding provided for seats).
- In 2018/19, MoH established an agreement with the Health Employers Association of BC for HCA recruitment services through Health Match BC. This agreement is for $2.26 million over 3 years.
- In 2020/21, the MoH has received approval to access Vote 52: Contingencies (All Ministries): Pandemic Response and Economic Recovery for up to Government Financial including funding to support training/education for HCAP in long term care/assisted living (including tuition costs and incidental education course work as required for the HCSW role) and for salaries under HCAP for up to 3,000 additional HCSWs.
- Based on the latest forecasts for 2020/21 only, up to Government to support wage and benefit costs related to the intake for the HCAP and Government Financial to cover the estimated tuition and supply costs for the education component (to be provided to post-secondary institutions via the AEST); however, until the close of fiscal 2020/21 the MoH will not be able to confirm the actual costs incurred related to this initiative.

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**Approved:**
February 28, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 7, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[10] Cliff# 1115957 BN, Advancing HCAs Education, Recruitment and Retention, Signed by the DM on Sept 18, 2018.
[11] B.C. seniors to get the hours of care they need as funding and staffing increased, Sept 25, 2018. https://news.gov.bc.ca/releases/2018PREM0072-001861
[12] Data received from BC Care Aide & CHW Registry, January 18, 2021

# LEGISLATIVE SESSION - FACT SHEET

## Health Career Access Program

### TOPIC

To provide a flexible pathway to rewarding careers in healthcare while taking decisive action to address persistent staffing challenges in the long-term care and assisted living sector, Government is implementing the new Health Career Access Program (HCAP). This program will enable the recruitment of 3,000 entry-level health care workers in long-term care (LTC) homes, assisted living (AL) facilities, and health authority owned and operated home health services across the province. Participants begin working as Health Care Support Workers (HCSWs) and receive employer-sponsored training that will lead to formal qualification as a health care assistant (HCA). [1]

### CURRENT SITUATION

- HCAP was part of a broader Government announcement regarding the recruitment of 7,000 individuals into the seniors' care sector, to date 5,330 positions have been filled across 3 initiatives.
- This includes 1,864 HCSWs hired through HCAP as of June 2nd, 2021. Of those, 662 have already begun their formal health care assistant training with recognized post-secondary institution.[2]
- Eligible employers include health authorities as well as contracted affiliate service providers and private employers that operate LTC and AL facilities.
- Presently, 2,406 HCSW positions have been provided to participating employers though a provincial allocation process. Recruitment is underway and the deadline for hiring is June 30, 2021.
- Expansion into home health is underway, which will fill the balance of the 3,000 positions.

### KEY FACTS

**Program Overview**

- On September 9, 2020, Government announced the recruitment of 7,000 individuals into the seniors' sector over 3 initiatives:
    1. 3,000 FTEs for the Health Career Access Program (HCAP);
    2. 2,000 positions to support visitation in long-term care and assisted living; and
    3. Recruitment support to fill 2,000 existing vacancies in long-term care and assisted living.
- As of June 2, 2021 over 5,330 positions have been filled including:
    - 1,864 participants hired into HCAP;
    - 1,521 FTEs hired to support the enhanced visitation policy support;
    - 1,945 baseline vacancies filled in HCA, food service and housekeeping positions.
- HCAP provides a work-integrated learning pathway that introduces the role of HCSW to the LTC, AL and home health sectors. HCSWs 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.
- 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; and
    - facilitate labour market transitions for British Columbians who face unemployment or underemployment due to COVID-19 or other factors.

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

2 Health Career Access Program (HCAP) Weekly Reports, May 26 2021.

- 3,000 net new HCSW positions are available and fully funded by the Province, including education and employment costs.

**Recruitment, Allocation, Matching and Hiring Processes**

- A provincial recruitment campaign was launched on September 9, 2020. This included a social media campaign, a recruitment website, and a Participant Expression of Interest (PEOI) process.
- Once they engage in the PEOI, interested individuals are connected with HCSW or other job opportunities in the LTC sector through an online employer portal developed specifically for HCAP.
- Regional Allocation Plans, finalized by the Ministry in November 2020 and updated in May 2021, 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.
- Final participant selection is employer driven and includes candidate vetting processes that are standard for the sector (e.g. Vulnerable Sector Criminal Record Checks).
- Minimum qualifications mirror those specified by the BC Care Aide and Community Health Worker Registry to enter HCA training (Grade 10, including the successful completion of English 10, or equivalency).

**Training**

- HCSWs receive a comprehensive 2-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 basis or full-time and interspersed with periods of employment. HCA training is provided by an approved post-secondary institution (PSI).
- The Ministry of Advanced Education received funding for 600 training seats in 2020/21 and a further 2400 through Budget 2021. The program is expanding to include select private institutions to meet training demand in a timely manner.
- 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.
- HCA students not participating in HCAP who began training in a standard HCA program between April 2020 and March 2021 are eligible for a recruitment incentive. The incentive includes a 12-month return of service.

**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 employment as a qualified HCA can begin.
- 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.

## FINANCIAL IMPLICATIONS

- As of March 31, 2021, $34.6 million provided for wage and benefit supports while individuals train as HCWS in LTC homes and AI facilities throughout the Province through the HCAP.
- A further $3 million provided in 2020/21 to the Ministry of Advanced Education and Skills Training to support direct program funding to post-secondary institutions.
- Budget 2021 provides $585 million over 3 years to continue support of the HCAP program to train, recruit and employ up to 3,000 health care workers.

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**Approved:**

June 2, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

June 7, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Health Profession Modernization

## TOPIC

- In response to Part 2 of the Cayton report the Honourable Adrian Dix, Minister of Health established the Steering Committee on Modernization of Health Professional Regulation to develop a proposal on modernizing the regulatory framework for health professions.
- On August 27, 2020, the steering committee released its final report, *Recommendations to Modernize the Provincial Health Profession Regulatory Framework*.
- The final report made recommendations in six areas of focus: cultural safety, improved governance, reducing the number of regulatory colleges for efficiency and effectiveness, strengthening oversight, improving the complaints process and transparency, and information sharing.

## CURRENT SITUATION

The authority to modernize the provincial regulatory framework rests with cabinet and the Legislative Assembly. Legislation which will put a modernized framework in place will be drafted and brought to the Legislative Assembly for consideration.

- Two college amalgamations were recently completed, reducing the number of colleges from 20 to 18.
- On August 31, 2020, the College of Physicians and Surgeons of BC and the College of Podiatric Surgeons of BC amalgamated.
- On September 1, 2020, the BC College of Nursing Professionals and the College of Midwives of BC amalgamated and became the BC College of Nurses and Midwives.
- The four oral health colleges (College of Dental Surgeons of BC, College of Dental Hygienists of BC, College of Denturists of BC, College of Dental Technicians of BC) have begun the process to move forward with amalgamation.
- Other contemplated amalgamations are awaiting changes proposed in the modernization recommendations.

## KEY FACTS

<u>Cayton Report</u>

- 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). The Report has two parts: Part 1 pertains to the College of Dental Surgeons of British Columbia (CDSBC), see Fact Sheet 'Cayton Report – Inquiry into CDSBC (Part 1)'. Part 2 makes suggestions on modernizing the health professional regulatory framework in BC.
- The Report found that the *Health Professions Act* (HPA) in its current form does not fully enable modern ways of regulating health professionals. The Report made a range of suggestions for modernization.
- **Governance** – colleges should have smaller, fully appointed boards with equal numbers of health professionals and public. Colleges should be fully separate from professional associations and not collect fees for them.
- **Merging colleges and moratorium** – the Ministry should actively encourage and facilitate voluntary regulatory college mergers and place a moratorium on creating any new colleges.
- **Oversight** – a new oversight body for health professional regulation should be established. The oversight body would create and oversee an independent appointment process for professional and public members of college boards, advise colleges and the Minister on improving regulatory practice, and conduct reviews into college performance, among other functions.
- **Registration and adjudication body** – A new professional registration and adjudication body should be created which would hold a single register of all regulated health professionals and manage the discipline process. Colleges would investigate complaints but not adjudicate.
- **College functions** – reconstitute the colleges as bodies responsible for setting standards and licensing health professionals.
- **Transparency** – Colleges should publish the most information possible, within legislation, about complaints.

# LEGISLATIVE SESSION - FACT SHEET

Steering Committee on Modernization of Health Professional Regulation

- The steering committee met regularly in 2019-20 to consider options and to develop a proposal on modernizing the regulatory framework for health professions.
- The Minister chaired the steering committee, which included MLA Norm Letnick, and MLA Sonia Furstenau.

Recommendations to modernize the provincial health profession regulatory framework

- The steering committee reviewed the 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. The committee reviewed and considered all feedback and published a *What We Heard* report on the Ministry's website.
- Feedback helped the steering committee to confirm and refine its final recommendations:
  1. **Commitment to cultural safety and humility** – That work be undertaken to determine how cultural safety and humility should be supported by the regulatory framework.
  2. **Improved Governance** –Boards should be smaller with equal numbers of public and registrant board members; all board members should be appointed via a competency-based process (shift away from election); and, board member compensation should be fair and consistent .
  3. **Reduction in the number of regulatory colleges from 20 to six** –Three existing regulatory colleges should remain:
     - The College of Physicians and Surgeons of BC (with the addition of Podiatric Surgeons);
     - The College of Pharmacists of BC; and,
     - The BC College of Nurses and Midwives

     Three new 'umbrella' or multi-profession regulatory colleges should be established:
     - An oral health regulatory college which would include the four current oral health regulators (College of Dental Surgeons of BC, College of Dental Hygienists of BC, College of Dental Technicians of BC, College of Denturists of BC);
     - A regulatory College of Allied Health and Care Professionals which should regulate dietitians, occupational therapists, opticians, optometrists, physical therapists, psychologists, and speech and hearing professionals, as well as diagnostic and therapeutic professions; and,
     - A regulatory College of Complementary and Alternative Health and Care Professionals which should regulate chiropractors, massage therapists, naturopathic physicians, and traditional Chinese medicine practitioners and acupuncturists.

     Consultation feedback helped the steering committee to refine its earlier proposal on a College of Health and Care Professions of BC, and to split that proposed college into the two latter umbrella colleges above.
  4. **Creation of an oversight body** – A 'regulator of regulators' should be established, to promote accountability, transparency and consistency across regulatory bodies. The oversight body should conduct routine audits of regulatory colleges based on clear performance standards, give guidance on regulatory policy and practice, and make recommendations on health occupations to be regulated under the HPA. The Health Professions Review Board should remain separate from this body (based on consultation feedback).
  5. **Improved transparency in complaints and adjudication** – A new discipline process should be established, to separate the investigation stage (which should remain with colleges) and the discipline stage (which should be supported by the oversight body). To increase transparency, information about all agreements made in future between colleges and registrants in complaints matters should be public. Colleges should fund counselling for victims of sexual abuse and sexual misconduct and should be able to recover costs from registrants who harm.
  6. **Information sharing** – Regulatory colleges should be enabled to share information between each other and with other agencies where necessary for public safety and protection.
- The decision to modernize the HPA sits with cabinet. Once that decision is made it will be brought to the legislature for consideration.

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

The annual cost of the oversight body and the estimated cost of amalgamation of the 11 colleges into one or two umbrella colleges is still to be determined.

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**Approved:**

February 12, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
June 14, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Professional Regulation – Regulatory Response to COVID-19

### TOPIC

As part of BC's COVID-19 response strategy, a number of regulatory actions, including amendments to health profession regulations, regulatory college bylaws and the development of Provincial Health Officer (PHO) Orders, have been required to support the timely delivery of safe health services and the efficient and effective use of health human resources.

### CURRENT SITUATION

The regulatory responses which have been brought into force to address COVID-19 will enable the Ministry to:

- Plan for and identify health professionals willing to be temporarily registered or willing to be deployed in the event there is a need.
- Allow the PHO to issue an order to deploy health professionals under the *Health Professions Act* (HPA) or Emergency Medical Assistants (EMAs) under the *Emergency Health Services Act* (EHSA) to work outside their scope of practice in response to COVID-19.
- Allow Regulatory Colleges to extend timelines as necessary for registration, licensing, exams and certification requirements.
- Support the PHO in developing orders to temporarily expand the scope of practise for regulated health professionals in response to COVID-19.

### KEY FACTS

**Amendments to Regulations [under HPA and EHSA] and PHO Orders**

- Amendments were made to the Health Professions General Regulation under the HPA to temporarily suspend timelines for the disposition of complaints by regulatory colleges (amendments came into force May 6, 2020, under Ministerial Order M146).
- Amendments were made to the Health Professions General Regulation and to the Emergency Medical Assistants Regulation under the EHSA, to give the PHO powers to authorize health professions and EMAs to work outside of their regulated scopes of practice in certain circumstances and when in the public interest during a public health emergency (amendments came into force May 6, 2020, under Ministerial Order M146).
- On May 7, 2020, the PHO issued an order allowing Licensed Practical Nurses to temporarily provide nasopharyngeal swabs and oropharyngeal swabs without a client specific order to screen for COVID-19 for the duration of the declared public health emergency.
- On November 16, 2020, the PHO issued 3 orders allowing for the temporary provision of nasopharyngeal swabs and oropharyngeal swabs to screen for COVID-19 during the declared public health emergency, to the following health professionals:
    - Order 1: midwives and certified practice speech language pathologists;
    - Order 2: speech language pathologists (not covered by the above order), physical therapists, dental hygienists, occupational therapists, dietitians, audiologists and pharmacists who are employed by a health authority; and
    - Order 3: EMAs in the licence categories of Primary Care Paramedic and Advanced Care Paramedic employed by BC Emergency Health Services as part of the Community Paramedicine Program. The order also authorized these EMAs to temporarily provide mouth rinse COVID-19 tests.
- For each of the May 7 and November 26, 2020 PHO orders, registrants must meet certain conditions (as outlined in the orders), which include the tests be administered in accordance with the BC Centre for Disease Control's guidelines and registrants complete required training and assessment prior to administering the tests.

# LEGISLATIVE SESSION - FACT SHEET

**Amendments to Bylaws [under HPA*, Pharmacy Operations and Drug Scheduling Act*) and other Regulatory Responses**

Extension of Timelines for Registration, Licensing, Exams and Continuing Education

Health regulators used the authority provided under PSSG Ministerial Order M098[1] to extend timelines as necessary for registration, licensing, exams and certification requirements. Some colleges also made specific changes to their bylaws relating to COVID-19 related examination delays:

- The College of Physicians and Surgeons:
  - temporarily amended its registration bylaws on May 27, 2020 and January 8, 2021 to waive the requirements for sponsorship and supervision of provisional registrants (recent residency graduates) who would have written spring qualifying exams but were delayed due to COVID-19. These registrants will be required to sit exams at the next available sitting;
  - amended its preregistration requirements on January 8, 2021 to enable residents unable to take the Medical Council of Canada Qualifying Examination Part 2 to be granted provisional registration without sponsorship or supervision until the first available sitting of the exam; and
  - amended its bylaws on January 8, 2021 to postpone the requirement for senior residents to take the clinical skills examination of the Medical Council of Canada to obtain registration in the Clinical Associate class of registration until such time as this examination is readily available.
- The EMA Licensing Board undertook actions related to examinations, licensing and continuing competence requirements under authority of PSSG Ministerial Order MO98 (for additional information see Fact Sheet 'Emergency Medical Assistants Licensing Board – Actions Taken to Support COVID-19').

Temporary Emergency Registration and Potential Redeployment of Health Professionals

- In response to an anticipated increase in demand for health professionals in health authority settings, and the potential need to redeploy private practitioners to fill gaps in service delivery, a number of health regulators amended their temporary emergency registration categories in their bylaws and/or canvassed existing registrants impacted by private practice closures about willingness to be redeployed.
- The following health regulators amended bylaws or used existing authority to create temporary emergency registration categories: College of Pharmacists; College of Dietitians; College of Psychologists; College of Physicians and Surgeons; College of Nursing Professionals; College of Midwives; College of Social Workers; and BC Care Aide & Community Health Worker Registry.

College of Pharmacists of BC (CPhBC) Bylaw Amendments

- In response to temporary exemptions made by Health Canada under section 56 of the *Controlled Drugs and Substances Act* to maintain Canadians' access to controlled substances for medical treatments, the CPhBC made the following amendments under the HPA and the *Pharmacy Operations and Drug Scheduling Act* Bylaws, which came into force on March 27, 2020:
  - amendment to the *Pharmacy Operations and Drug Scheduling Act* Bylaws permits pharmacists to dispense controlled substances upon receipt of a verbal prescription from a practitioner (as permitted under a section 56 exemption of the *Controlled Drugs and Substances Act*;
  - amendment to the Community Pharmacy Standards of Practice (HPA Bylaws) allows for the transfer of a prescription for a controlled drug substance from one pharmacist to another;
  - amendments to the Community Pharmacy Standards of Practice and the Residential Care Facilities and Homes Standards of Practice (HPA Bylaws Schedule F Part 1 and Part 3) acknowledge the validity of verbal prescriptions; and
  - related amendments to CPhBC's Professional Practice Policy PPP-71 allow for pharmacists to authorize regulated health professionals to deliver opioid agonist treatment.

1 PSSG Ministerial order M098 came into force on March 26, 2020 (amended April 15) and allows for a person, tribunal or other body that has a statutory power of decision to waive, suspend or extend a mandatory time period relating to the exercise of that power.

- In response to a number of the drugs used in the MAiD intravenous drug protocol being included on Health Canada's "Tier 3 Drug Shortages" list (due to also being used in the critical care of patients with COVID-19), CPhBC made amendments to the HPA and PODSA Bylaws to temporarily allow pharmacists to accept for return to inventory unused injectable drugs dispensed for the purpose of MAiD, when conditions are met to ensure drug integrity.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 12, 2021 – Ian Ronge, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Science Professionals Bargaining Association Collective Agreement

### TOPIC

The Health Science Professionals Bargaining Association (HSPBA) and the Health Employers Association of BC (HEABC) 2019-2022 Collective Agreement.

### CURRENT SITUATION

Negotiations for a new agreement under the Sustainable Services Negotiating Mandate began in September 2018, a tentative agreement was reached on November 8, 2018 and the collective agreement was ratified on February 15, 2019.

### KEY FACTS

- The HSPBA collective agreement covers approximately 18,886 active employees (13,889 full time equivalents (FTEs)) and represents an estimated $1.430 billion in annual expenditure on compensation.[1]
- Most HSPBA members are represented by the Health Sciences Association (15,241 members, 82% of FTEs), and others are represented by the BCGEU, Canadian Union of Public Employees, Professional Employees' Association and the Hospital Employees' Union.
- Classifications in the HSPBA range from medical and laboratory professionals to pharmacists, psychologists, occupational therapists, social workers and physiotherapists. The most populated classifications in the HSPBA are medical laboratory technologists, medical radiation technologists and physiotherapists.
- Employers pay 100% of the premiums for dental, extended health, and group life and 70% of the premium for long-term disability insurance for HSPBA members.
- Regular health science professional employees and their employers contribute to a defined benefit pension plan, the Municipal Pension Plan.
- In July 2018 a one-time funding allocation of $3 million was set aside by the Ministry of Health for the professional development for HSPBA members. The funding is being allocated proportionally across three areas: retraining of existing HSPBA members for professions which are in short supply in BC, professional development for those in rural and remote settings, and ongoing required professional development for all members.

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

- The HSPBA and HEABC ratified a new three-year collective agreement on February 15, 2019 under the Sustainable Services Negotiating Mandate.
- Highlights of the three-year collective agreement include:
  - General wage increases of 2% annually in 2019, 2020, and 2021.
  - $10 million to fund the first step toward restructuring the classification system to address inequities in job categories. Full implementation of the restructuring will bring grade one and non-graded staff to grade two pay rates and will provide a one-grid increase to all staff receiving miscellaneous rates of pay.
  - Working groups to address occupational health and safety and workload concerns.
  - A new domestic and sexual violence leave policy (up to 17 weeks unpaid leave).
  - The striking of Appendix 18 which allowed for contracting out of non-clinical services (to align with the passing of Bill 47, which repeals Bills 29 and 94).
  - Gender neutral language.

### FINANCIAL IMPLICATIONS

The HSPBA collective agreement represents an estimated $1.43 billion in annual expenditure on compensation. A 1% increase to compensation represents approximately $14 million.[2]

[1] PSEC. 2019. "Public Sector Compensation Annual Forecast 2019 (unreleased).", pg. 33
[2] PSEC. 2019. "Public Sector Compensation Annual Forecast 2019 (unreleased).", pg. 33

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
January 25, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Hiring of Contact Tracers

### TOPIC

To support the COVID pandemic response, the Province is hiring approximately 1,500 additional contact tracers across BC.

### CURRENT SITUATION

- As of May 28, 2021, health authorities report[1] that across BC there are a total of 1,563 total hires. Most health authorities have surpassed their targets and any further recruitment activities are focused on backfilling to account for attrition.
- These positions have all been approved to continue, based on guidance from the Provincial Health Office.
- In addition, Statistics Canada is providing contact tracing resources to Fraser Health Authority (FHA) as needed. They began work on November 24, 2020, to support FHA's contact tracing team (not included in hiring numbers).
- The Ministry is also working with Service BC to provide additional contact tracing support to the health authorities as needed. Service BC started supporting Interior Health on December 30, 2020.
- Of those hired to date, 40% are internal hires (hired from within the health authority) and 60% are external hires.
    - Of the internal hires, 82 are "duty to accommodate" employees – or those who have been reassigned from other areas of the health authority for health or safety issues.
    - In some health authorities, internal hires have had to be redeployed back into their base positions due to increased need across other critical areas of the health system.
- The breakdown of professions hired, as of May 28, 2021, are:
    - Nurses (LPNs and RNs): 667
    - Contact tracer aides or assistants: 587
    - Environmental health officers/allied health: 309
- The Ministry approved First Nations Health Authority to hire community health representative positions to support culturally safe contact tracing efforts within First Nations communities.
- FNHA is supporting sub-regional, nation, and community models for these positions. A total of 75 communities have been allocated funding for this initiative. Each has a slightly different roll-out model, depending on the unique needs of their region, Nation or community.
- Across those 75 communities, funding has been provided for a total of 98 FTEs.
    - This represents an increase from the initially approved FTE total of 76, due to efficiencies in planning and collaboration.
    - Of those 97 FTEs, 83 FTEs have been confirmed to have been recruited to date.
    - All new hires go through a training program that is centrally coordinated by FNHA and will include modules on public health, privacy and confidentiality, trauma-informed care, harm reduction and infection prevention and control.
    - Communities report that the liaison role continues to fill a crucial function as exhaustion and burnout increase among health directors and other health staff. They continue to support emergency response, food security (groceries), health check-ins, contact tracing in partnership with regional health authorities as appropriate, medication support in community. In addition, they have provided outreach to Elders, vulnerable community members and anyone who is self-isolating or in quarantine.
    - Communities report that the liaison role has fulfilled a crucial need in the community and has given support and respite to the Health Director and other Health staff.

  For additional details on hiring numbers, please see latest Contact Tracing Report.

[1] Data self-reported by health authorities to the Provincial Health Services Authority. May 2021.

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

- On August 12, 2020, Premier Horgan and Minister Dix announced an initiative to hire approximately 500 contact tracers across the province to support ongoing COVID-19 efforts, particularly in advance of a second wave.
  - The number of total positions to be hired increased in September to 645, and then further increased in December to 1,224 FTEs.
  - Health authorities have completed over 100% of this new target.
- Contact tracers hired are a mix of registered health professionals (registered nurses, licensed practical nurses and others) and contact tracing aides, which are entry-level positions that do not require a health background. These individuals are hired by the RHAs and the PHSA into the rapid response pool. The rapid response pool has the capability to be deployed anywhere in the province as needed, or provide regional support from the Contact Tracing Hub at the Vancouver Convention Centre. Feedback on hiring of contact tracer aide positions is that a number are coming from industries particularly hard hit by COVID, such as hospitality and airline industry.
- This team-based model has helped to optimize the nursing workforce and reduced potential disruption to the existing nursing workforce. The majority of health authorities followed this strategy.
- Health Match BC (HMBC) supported recruitment of these positions, by providing intake and initial assessment and referring on to health authorities as appropriate. HMBC also created a landing page to receive general expressions of interest or inquiries about this program from the public: www.healthmatchbc.org/ContactTracers
- Health authorities posted these positions both internally and externally, in keeping with appropriate collective agreements.
- These positions also provide additional public health services as needed to support the COVID response, including providing immunizations, testing result follow-up and/or education.
- Employment was initially planned until the end of March 2021, but all positions have been approved to be extended to September, as needed.
- Prior to the launch of this expanded contact tracer hiring initiative, there were 667 people available/trained to do contact tracing across the health authorities; with about 260 actively working in that area.
- The number of contact tracers allocated to each HA, based on the need:

| Health Authority | Approved Resources (head count) | Approved Resources (FTE) | Hired to Date (head count) | Hired to Date (FTE) | Notes |
|---|---|---|---|---|---|
| **Vancouver Coastal Health** | 252 | 229.55 | 294 | 203.07 | Surpassed target (casuals not included in FTE count) |
| **Fraser Health** | 555 | 536.8 | 637 | 445.78 | Surpassed target |
| **Island Health** | 121 | 47 | 118 | 98.4 | |
| **Interior Health** | 59 | 59 | 64 | 57.44 | Surpassed target |
| **Northern Health** | 37 | 38 | 182 | 67.31 | Surpassed target |
| **PHSA** | 250 | 250 | 268 | 205.3 | Met target |
| **Total** | 1274 | **1,160.35** | **1,563** | **1077.3** | |

## FINANCIAL IMPLICATIONS

In 2020/21, the Ministry has allocated up to $60.5 million to the health authorities, including PHSA, to hire staff to perform contact tracing activity until March 31, 2021.

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**Approved:**

February 23, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
February 24, 2021 – Darlene Therrien obo Ian Rongve, ADM, COVID Response and Health Emergency Management Division
May 27, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

# 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.

## CURRENT SITUATION

- 51 IMGs (42 Family Medicine; 9 Specialty) started their Return of Service (ROS) in 2020.[1]
- As of January 22, 2021, 319 family physicians and 54 specialists have been placed in 89 communities.[2]
- Timelines for national examinations have been impacted as a result of COVID-19.
  - The Medical Council of Canada (MCC), responsible for assessing IMGs seeking to practice medicine in Canada, continues to closely monitor the COVID-19 situation and potential impacts on future exams. The MCC is exploring the option of virtual delivery for Objective Structured Clinical Examinations to mitigate against the challenges of in-person exam delivery due to the pandemic.[3]
  - The 2020 UBC Clinical Assessment Program (CAP) will be delivered virtually in January 2021.[4]
  - All written and applied exams offered by the Royal College of Physicians and Surgeons of Canada (RCPSC) will be delivered online in 2021.[5]
  - The oral exam component of the College of Family Physicians of Canada (CFPC) Certification exam is not required for candidates writing the Certification exam for the first time in 2021.[6]

## KEY FACTS

IMGs are a diverse group of Canadian citizens (or permanent residents) who complete their medical education at medical schools (listed in the World Directory of Medical Schools) outside of Canada or the United States.

Medical Education and Residency

- 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[7] including the:
  - Medical Council of Canada Qualifying Examination Part 1 (MCCQE1)[8] – a summative examination assessing critical medical knowledge and clinical decision-making ability; and,
  - National Assessment Collaboration – an objective structured clinical exam (OSCE) which is a series of mock clinical situations with standardized patients in designated stations.
- 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.[9]
- 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 US. 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).

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[1] Physician Services Branch, Health Sector Workforce and Beneficiary Services Division, Ministry of Health. (2021). IMG-BC Community Placements. Data as of January 22, 2021.
[2] Ibid.
[3] MCC. (2020). Update on COVID-19. https://mcc.ca/about/covid-19/. Last accessed January 20, 2021.
[4] UBC Faculty of Medicine. (2021). Clinical Assessment Program. https://imgbc.med.ubc.ca/clinical-assessment/. Last accessed January 20, 2021.
[5] RCPSC. (2021). 2021 Exams Update. https://newsroom.royalcollege.ca/2021-exams-update-introducing-online-exams-for-all/. Last accessed Jan 20, 2021.
[6] CFPC. (2021). Impact of Covid-19 on Certifications and Exams. https://www.cfpc.ca/en/education-professional-development/examinations-and-certification/certification-examination-in-family-medicine/impact-of-covid-19-on-certification-and-examinati. Last accessed January 20, 2021.
[7] Medical Council of Canada (MCC). (2016). *National Assessment Collaboration.* MCC. Retrieved Jan 15, 2016 from http://mcc.ca/examinations/nac-overview/
[8] Medical Council of Canada (MCC). (2019). *MCCQE Part 1*. Retrieved Feb 13, 2019 https://mcc.ca/examinations/mccqe-part-i/
[9] UBC Faculty of Medicine. (2021). IMG-BC Clinical Assessment Program. Retrieved January 22, 2021 from https://imgbc.med.ubc.ca/clinical-assessment/

- 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.
- In 2020, 1,435 IMGs applied for 325 IMG-dedicated residency positions through CaRMS.[10]

Reducing Barriers to PGME

- IMG entry-level PGME positions at UBC have increased from 6 in 2003 to 58 (52 Family Medicine; 6 general specialty) as of 2019, including 40 new positions since 2011[11]. Priority was 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 Student Elective 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 experiences in BC's heath care system and demonstrate their clinical skills. There will be no visiting electives for the Class of 2021 for the duration of the 20-21 academic year due to the ongoing uncertainty of COVID-19.[12]

Return of Service (ROS)

- Residents selected into UBC IMG positions must complete a ROS in a health authority-identified community upon finishing their residency program.
- Residents engage in a competitive application process and interview with clinics in selected communities to determine their ROS placement.
- Residents in Family Medicine complete a two-year ROS; other specialities complete a three-year ROS.

## FINANCIAL IMPLICATIONS

- In 2019/20, the Ministry provided $151.8M to UBC Faculty of Medicine to support PGME.
- In 2020/21, the Ministry has committed up to $155.84 million to UBC Faculty of Medicine to support PGME.

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**Approved:**
January 31, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 10, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[10] CaRMS (2021). R-1 Data and Reports:2020 R-1 Match Reports Table 1 and Table14. https://www.carms.ca/data-reports/r1-data-reports/ Last accessed Jan 14, 2021.
[11] Ministry of Health. (2016). "UBC Kelleher 2016/17 PGME Funding Letter." Cliff 1065613
[12] AFMC Student Portal (2020). COVID-19 Updates: June 18, 2020 -Visiting electives for class of 2021. https://www.afmcstudentportal.ca/covid-19. Last accessed January 20, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## International Student Health Fee

### TOPIC

- In the course of developing policy for the elimination of Medical Services Plan (MSP) premiums effective January 1, 2020, it was noted that some populations in BC that are eligible for MSP enrolment would not be contributing to general taxes that help, in part, to fund BC's health care programs.
- Effective September 1, 2019 a health fee for international students enrolled in MSP with a study permit was introduced.

### CURRENT SITUATION

- Enrolment in MSP for international students has declined, potentially due to the COVID-19 pandemic.
- In May of 2020 there were 91,597 international students. As of December, there was 71,057 international students enrolled in MSP. [1]

### KEY FACTS

- The implementation of the international student health fee does not impact existing MSP eligibility requirements.
- A person must meet the residency requirements in the *Medicare Protection Act* and the Medical and Health Care Services Regulation to qualify for MSP enrolment.
- Individuals must self-identify to MSP for enrolment and are responsible for informing MSP if they leave the province. If they have left the country but did not advise Health Insurance BC, they would continue to be sent over in the monthly file to RSBC who would continue to bill the individual.
- Some international students may be studying online due to the COVID-19 pandemic. Individuals who meet the eligibility requirements and are studying online are still subjected to the health fee. The fee is tied to the study permit, not the type of educational institution or program they attend.
- The health fee is billed to both K-12 and post secondary students enrolled in MSP with a study permit at $75 per month, per student.
- As of January 1, 2020, the authority to charge the health fee is through directive M483 under the *Financial Administrative Act.*
- There is no financial assistance program available for the health fee.
- As of December 31, 2020, there were 71,057 international students enrolled in MSP
    - 57,669 of those students are over the age of 19.
    - 13,388 of those students are under the age of 19.

### FINANCIAL IMPLICATIONS

- The Ministry of Finance and Revenue Services of BC is responsible for billing and collection of the health fee.
- For accounts that have an outstanding balance, soft collections activities resumed in October.

Government Financial Information

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**Approved:**
January 25, 2021 -Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[1] Health Insurance BC, RAPID
[2] Ministry of Finance

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Cabinet Confidences ; Advice/Recommentations ; Government Financial Information

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Cabinet Confidences ; Advice/Recommentations ; Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

## Medical Device Reprocessing Techs

### TOPIC

- Medical Device Reprocessing Technicians (MDRTs) gather, disassemble, clean, disinfect, assemble, package, sterilize, store and distribute surgical instruments, supplies and equipment for re-use in a health care facility.[1]
- MDRTs are an essential part of hospitals and play a critical role in achieving meaningful health outcomes by increasing operating room utilization, increasing surgical procedures performed, preventing delay of surgeries due to lack of sterile equipment, and infection control.
- The increased training of MDRTs supports a strategy from *A Commitment to Surgical Renewal in BC* and meets population health needs by allowing quicker access to surgery, fewer delays, and adequate staffing levels to manage the new surgical capacity.[2]
- Some health authorities communicated through correspondence with the Ministry of Health that they have faced challenges recruiting and staffing MDRTs in rural and remote locations; and that these challenges have been exacerbated as a result of the COVID-19 pandemic.

### CURRENT SITUATION

- There are four post-secondary institutions (PSIs) that provide MDRT training in the province: Vancouver Community College (30-48 seats), Vancouver Island University (16-24 seats), Okanagan College (18 seats) and the College of New Caledonia (8 seats)[3].
- The salary for an MDRT is consistent throughout the province at $24.50 per hour.[4]
- Classroom size can vary year-to-year, the limiting factor is the HA's ability to accommodate students for the supervised practicum.
- Education programs from the four PSIs range from four to eight months in length, with an average duration of 4.5 months. The program is a mix of classroom theory supported by a supervised practicum within a health authority (HA) hospital site.
- On May 5, 2020, as a result of COVID-19 delaying and postponing approximately 30,000 surgeries, the Honorable Minister Dix and Michael Marchbank released the *Commitment to Surgical Renewal in BC* to add new capacity, hire and train staff to support rescheduled the cancelled surgeries.[2]
- The Commitment to Surgical Renewal in BC outlined that across the province approximately 100 new MDRTs would need to be trained to meet surgical demand.[4] This is in addition to the ~120 average annual graduates from BC programs, most of whom are hired directly into health authorities.[3]
- The Ministry of Health has been working with health authorities (HAs), the Ministry of Advanced Education and Skills Training (AEST) and post-secondary institutions (PSIs) to provide salary, tuition and clinical instruction support funding for HA-sponsored employees to undergo MDRT training.
- Approximately 50 HA-sponsored employees are undergoing MDRT training this Winter, 2021.

### KEY FACTS

- HAs identified through regular correspondence to the Ministry of Health in September 2020 that an additional 131 MDRTs would be required to support the Surgical Renewal strategy.[5] Strategies to fill included conversion of casual/part-time staff, hiring from existing post-secondary programs, and sponsoring existing employees to become MDRTs.
- Clinical practicum opportunities have been under increased pressure as a result of COVID-19. Funding was provided to the HAs for support (see Financial Implications) to alleviate these constraints.

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[1] https://assesshealthcareers.ca/data/documents/pdf/medicaldevicereprocessingtechniciansh.PDF
[2] https://www2.gov.bc.ca/assets/gov/health/conducting-health-research/surgical-renewal-plan.pdf
[3] Confidential information provided by the Ministry of Advanced Education and Skills Training on July 15, 2020
[4] Nursing Assistant II (Sterile Supply) https://www.heu.org/sites/default/files/imce-uploads/HEABC-FBA%202020-2022%20Wage%20Schedules-April2020.pdf
[5] Correspondence including email, Skype, Teams, and phone calls

- The Ministry is working closely with the AEST and the health authorities to project workforce planning numbers for the HAs, and to identify the anticipated numbers of graduates from the MDRT programs.

## FINANCIAL IMPLICATIONS

- There were two phases of funding that occurred:
  - Clinical Support/Onboarding Funds for Phase 1: The Ministry provided approximately $1.25 million to the HAs – with the exception of $100,000 that was provided to AEST to support the Okanagan College in retaining an additional faculty member for a January 2021 cohort.
  - Wage and Salary for Phase 2: Each HA was given funds for salary and tuition to support sponsored employees to undergo MDRT training. HAs were provided with $20,000 per employee for a wage stipend and $10,000 per employee for tuition and books for a total of $1.53 million.
- HAs are currently assessing their training needs for a potential third funding phase in the 2021/22 fiscal year.

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**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 24, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Midwifery Program

### TOPIC

Update on the Midwifery Program.

### CURRENT SITUATION

Midwifery services are a benefit under the BC Midwifery Program for eligible BC residents enrolled with the Medical Services Plan (MSP). They are funded by the Ministry of Health.

### KEY FACTS

- 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.
- Midwifery services are a benefit of the MSP. Midwifery coverage through the MSP is based on a payment model that provides payment for all Midwifery Services rendered in each of the five phases of a Full Course of Care (FCC) from conception up to and including six weeks postpartum.
- The Midwives Association of BC (MABC) negotiates a contract with the Province for all registered midwives; in addition, the MABC provides professional liability insurance and continuing education opportunities for midwives.
- The BC College of Nurses and Midwives (BCCNM) is the regulatory body for the profession of midwifery in BC and exists to protect the interests of the public. Midwives practicing midwifery in BC must be registered with the College.
- As at March 31, 2020, BCCNM had a total of 405 midwife registrants (316 practicing; 89 non-practicing).[1]
- The current Midwifery Master Agreement is in force from April 1, 2014 to March 31, 2019. The Agreement was negotiated to confirm overarching principles and processes for the relationship between the Province and MABC. The Agreement also increases support for midwives who provide home birth to clients who choose to deliver at home and can safely do so. The key features of the current Midwifery Master Agreement include:
    - General fee increases as follows: April 1, 2015–1.0%, April 1, 2017–0.75% and April 1, 2018-0.75% with an entitlement to an Economic Stability Dividend. The final Economic Stability Dividend as part of the Midwifery Master Agreement provided a 0.75% increase to all midwifery fee codes effective February 1, 2019.
    - A one-time lump sum payment of $500 per each of 249 eligible Midwives (as determined by the MABC).
    - Renewal of the Midwifery Rural Services Subsidy Agreement, which includes $1,595,000 in total funding for the Rural Midwifery Locum Program and $680,000 in total funding for the Midwifery Rural Practice and Support Grant Program over the 5-year term of the agreement.
        - A Midwifery Rural Practice Committee has been created with the aim of strengthening midwife recruitment and retention in rural BC and addressing integration of midwife services in addition to improving collaboration between midwives and other health professionals. The Committee is made up of representatives from the Ministry, MABC and health authorities.
    - Funding for Continuing Midwifery Education (totaling $621,500 over the 5-year agreement).
    - The establishment of the following committees:
        - Rural Practice Committee (as above);
        - Fee Advisory Committee (includes $500,000 in total in committee funding over the 5-year term and a commitment of $250,000 for new fees over the term of the agreement); and
        - Perinatal Steering Committee and Midwifery Liaison Committee.

[1] BCCNM Annual Report 2019 – 2020, https://www.bccnm.ca/Documents/governance/annual_reports/legacy_colleges/CMBC/CMBC_annual_report_2019_20.pdf

  - Funding for Integration and Committee Support (totaling $520,000 over the 5-year term).
  - The Ministry has agreed to provide funding for a paid preceptorship of Midwives through agreement with the University. Government has committed to $1,650 per student per term[2] for a cost of $183,375 (2019/20).
- The Ministry continues to provide funding for the Rural Midwifery Locum Program, the Rural Practice and Support Grant, and Continuing Education prorated from the existing Midwifery Master Agreement while it negotiates a new agreement.
- The Ministry and the MABC attempted to reach a new negotiated agreement throughout 2019 and the spring and summer of 2020 and were unsuccessful. In August 2020, the MABC's membership voted to proceed to binding arbitration. The Ministry is now preparing for arbitration.
- In 2020, five pilot salary contracts for midwives in the north were introduced.
- Effective April 1, 2020, the Ministry made temporary amendments to several of the Consultative Care and Assessment fee codes to support midwives in providing consultative care and to ensure continuity of care for pregnant/postpartum women during COVID-19.
- The Ministry is currently in the process of establishing new temporary fee codes to compensate midwives for providing respiratory immunizations (including COVID-19 immunizations) and performing COVID-19 screening.
- In November 2020, the Ministry collaborated with MABC to secure Personal Protective Equipment (PPE) free of charge for midwives during the COVID-19 pandemic response.
- The University of BC (UBC) has offered a 4-year Midwifery baccalaureate degree program since September 2002. The program admits 20 students per year.[3]
- As of January 2016, UBC has an Internationally Educated Midwifery Bridging Program that offers 8 seats per year.[4]
- As of Sept. 21, 2020, the Ministry aligned nursing and midwifery within one policy area in the Nursing Policy Secretariat to build collaborative policy connections between nursing and midwifery within the Ministry and with external health system partners.
- The Nursing Policy Secretariat, in partnership with MABC, has established the Midwifery Advisory Committee comprised of Ministry representatives, MABC, and key midwifery partners to address priority issues including health system integration, policy development, building sustainable infrastructure, and enhancing access to services.

## FINANCIAL IMPLICATIONS

- In 2019/20, the midwifery services cost approximately $37.2 million[5] in fees and $1.25 million in MABC payments.
- The midwifery services budget for 2020/21 is $41.6 million.

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**Approved:**
January 26, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
January 29, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division

[2] Correspondence sent to UBC from Manjit Sidhu, Assistant Deputy Minister, Finance and Corporate Services. August 28, 2014. Cliff # 1015786
[3] Email confirmation from the Ministry of Advanced Education, Skills and Training to the Nursing Policy Secretariat, Jan. 15, 2021.
[4] Ibid.
[5] Other Health Practitioners Monthly Report – December 31, 2020

# LEGISLATIVE SESSION - FACT SHEET

## Moratorium on Applications for New, Expanded or Relocated Diagnostic Ultrasound Facilities in BC

### TOPIC

Applications for new, expanded or relocated outpatient diagnostic ultrasound facilities have been under province-wide moratorium since December 2012.

### CURRENT SITUATION

- The moratorium has been extended to June 1, 2022 and is the direct result of a significant and continued shortage of sonographers across BC.
- The high demand for ultrasound services is likely to increase as the health system works to mitigate wait times that were expanded as a result of the COVID-19 pandemic.
- All current facilities continue to operate. No services have been discontinued and no significant patient disruption experienced or anticipated.

### KEY FACTS

- The current moratorium on applications for new, relocated or expanded outpatient ultrasound facilities was established by the Medical Services Commission (MSC) in 2012.
- The ultrasound moratorium was determined to be necessary due to the long-standing shortage of ultrasound technicians (sonographers) in BC.
- The moratorium was scheduled to be lifted June 1, 2020, however on April 15, 2020 the MSC extended the moratorium until June 1, 2022.
- The moratorium applies to:
    - Applications for outpatient diagnostic ultrasound facilities in BC;
    - Applications for new facilities, as well as expansion or relocation of an existing facility; and
    - Both health authority and privately-owned facilities.
- The moratorium is intended to protect the capacity of existing hospital-based programs to deliver ultrasound to inpatients, emergency department patients and outpatients, by reducing competition for sonographers, particularly from new, privately-owned community imaging clinics, which tend to offer more attractive wages and working hours (no evenings/weekends, less complex procedures).
- The concern is that any expansion in community imaging clinics services is likely to draw sonographers away from health authority programs, which could impact essential hospital in-patient and emergency services.
- Exceptions to the current moratorium include:
    - Ultrasound fee items currently restricted to public hospitals i.e. Echocardiography and cardiac-related Doppler Studies;
    - Applications to add new services to an existing *Certificate of Approval*; and
    - Demonstrated urgent health or safety needs, as determined by the MSC.
- Impacted stakeholders are informed and aware of the moratorium, and the moratorium announcement and exception request process details are posted to the Ministry's Diagnostic Services website.
- Sonography was identified in government's *Labour Market Outlook: 2019 Edition* as a high demand health occupation in BC.[1] The Ministry's provincial health workforce planning process identified sonographer as a priority profession with labour market challenges.
- Through the 2019/20 Provincial Health Workforce Planning process all regional health authorities indicated that sonography was considered a priority or high priority. Recruitment was noted as difficult due to a variety of issues, most notably significant compensation competition with the private sector and other jurisdictions, high injury rates and difficulty recruiting to rural areas.

[1] Labour Market Outlook: 2019 Editionhttps://www.workbc.ca/getmedia/18214b5d-b338-4bbd-80bf-

- The BC Institute of Technology (BCIT) offers a 40 seat, 27-month diploma program with 46 weeks of clinical experience. BCIT has been funded for an additional 8 seats in February 2021, which will result in 48 seats offered annually through BCIT at steady state[2]. Students train in general or cardiac sonography or a dual general/cardiac option.
- The College of New Caledonia in Prince George launched a 24-month diploma program in January 2019 with a one-time cohort of 8 students. A full cohort of 16 students was launched in September 2019. This program will continue to offer 16 seats annually each September and train students in general and cardiac sonography[3].
- Camosun College in Victoria will launch a new sonography program in May 2021, with a cohort of 16 students annually in the 2-year program.[4]
- It is expected that total potential annual sonography graduates in BC will reach 80 by 2023, as a result of the new programs and seat expansions[5].

## FINANCIAL IMPLICATIONS

N/A

**Approved:**
February 11, 2021– Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services

[2] Source: Diagnostic Medical Sonography Fact Sheet, January 2021 .
[3] Source: Ibid.
[4] Ibid.
[5] Ibid.

# LEGISLATIVE SESSION - FACT SHEET

## MSP Coverage of Textured Breast Implant Removal

### TOPIC

Medical Service Plan (MSP) coverage of textured breast implant removal due to risk of BIA-ACLC.

### CURRENT SITUATION

- MSP covers the removal of all textured and unknown implants (including capsulectomy) if there is a reasonable basis to conclude that the procedure is medically required. Replacement costs are also covered if the original implants were related to a medically necessary procedure such as breast reconstruction following cancer. Physicians are asked to request pre-approval for these procedures through Health Insurance BC (HIBC).
- This approach is consistent with MSP's policy of covering breast implant removal when medical complications arise and the practice in most other provinces/territories (jurisdictions) in Canada.
- Since 2016/17, MSP has paid $1,881,576 for the cost to remove textured breast implants (including replacement when necessary) under fee codes 6164, 6165, 6178 and 6179.[1]

### KEY FACTS

- Breast implants are medical devices made of smooth or textured silicone shell filled with either silicone gel or saline. They are used for increasing breast size (cosmetic), correcting breast unevenness or appearance, or breast reconstruction following surgery such as a mastectomy.[2]
- The total number of people with breast implants in British Columbia is unknown because most surgeries are private cosmetic procedures.
- Anaplastic Large Cell Lymphoma (ALCL) is a rare type of T-cell Lymphoma, or cancer of the immune system. Rarely, ALCL can develop in the tissue around a breast implant, referred to as breast implant associated ALCL (BIA-ALCL)[3]
- According to Health Canada, individuals with highly textured implants are at increased risk compared to those with less textured or smooth implants. [4]
- On May 27, 2019, Health Canada notified Allergan of the suspension of the licenses for Biocell breast implants, the only macro-textured breast implants currently available in Canada.[5]
- The current rate of BIA-ALCL in Canada varies depending on the type of breast implant, from 1 in 3,565 for Allergan Biocell macro-textured breast implants to 1 in 16,703 for Mentor Siltex macro-textured breast implants,[6] but this may change as more cases of BIA-ALCL are reported.
- Health Canada does not recommend preventative removal in the absence of symptoms suggestive of BIA-ALCL. It instructs patients to discuss the risks and benefits of removal with their healthcare professional if they have concerns.
- The Doctors of BC Section of Plastic Surgery has raised concerns with the adequacy of resources available to manage medically indicated operations and patients without any medical indication choosing to have their textured implants removed.[7]

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[1] Integrated Analytics: Primary Care, Acute Care and Workforce; Health Sector Information Analysis and Reporting Division, Ministry of Health. MSP funded breast implant replacements and removals, data as of September 30, 2020 (PAS 3000.1638)..

[2] Health Canada. *Breast Implants - Risk of Anaplastic Large Cell Lymphoma (BIA-ALCL).* https://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65188a-eng.php. Last accessed September 10, 2020.

[3] Canadian Cancer Society. *Anaplastic large cell lymphoma.* https://www.cancer.ca/en/cancer-information/cancer-type/non-hodgkin-lymphoma/non-hodgkin-lymphoma/more-types-of-nhl/anaplastic-large-cell-lymphoma/?region=on. Last accessed September 10, 2020.

[4] Health Canada. *Breast Implants - Risk of Anaplastic Large Cell Lymphoma (BIA-ALCL).* https://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65188a-eng.php. Last accessed September 10, 2020.

[5] Health Canada. *Summary Safety Review - Breast Implants - Health Canada.* https://hpr-rps.hres.ca/reg-content/summary-safety-review-detail.php?lang=en&linkID=SSR00223. Last accessed September 10, 2020.

[6] Health Canada. *Health Canada suspends Allergan's licences for its Biocell breast implants after safety review concludes an increased risk of cancer.* https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2019/70045a-eng.php. Last accessed September 10, 2020.

[7] Email, Dr Owen Reid. Head of Plastic Surgery, Doctors of BC. September 16, 2019.

- The *Medicare Protection Act* prohibits plastic surgeons that perform publicly insured breast implant removals and replacements in private clinics from charging patients any additional fees for the insured service, e.g. work up fees and facility fees.[8]
- On November 28, 2019, MSP sent a letter to the Doctors of BC Head of Plastic Surgery further clarifying MSP coverage of textured breast implant removal and replacement, and when the legislation permits physicians to bill privately for this service.

## FINANCIAL IMPLICATIONS

- Combined expenditures on fee items for breast implant removal and replacement have been increasing since 2016/17.[9]

| | 2016/2017 | | 2017/2018 | | 2018/2019 | | 2019/2020 | |
|---|---|---|---|---|---|---|---|---|
| Fee Item | Paid Services | Expenditure | Paid Services | Expenditure | Paid Services | Expenditure | Paid Services | Expenditure |
| 6164 - Breast Replacement - Unilateral | 325 | $73,445 | 412 | $141,581 | 439 | $156,085 | 404 | $140,318 |
| 6165 - Breast Replacement - Bilateral | 327 | $164,677 | 353 | $210,990 | 340 | $203,426 | 348 | $208,246 |
| 6178 - Breast Implant - Excision/Pathologic Capsule | 375 | $100,610 | 374 | $95,021 | 438 | $109,254 | 570 | $167,385 |
| 6179 - Breast Implant - Excision Only | 140 | $25,033 | 130 | $22,373 | 150 | $26,527 | 203 | $36,603 |
| **Total** | **1,167** | **$363,765** | **1,269** | **$469,966** | **1,367** | **$495,292** | **1,525** | **$552,553** |

- Future expenditures are unknown as the number of British Columbians with textured breast implants who will seek to have them removed and replaced is unknown.

**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 20, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 28, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[8] Medicare Protection Act. *Part 4 - Limits on Billing, Section 18(3).* http://www.bclaws.ca/civix/document/id/complete/statreg/96286_01#part4. Act current as of August 12, 2020.
[9] Integrated Analytics: Primary Care, Acute Care and Workforce; Health Sector Information Analysis and Reporting Division, Ministry of Health. MSP funded breast implant replacements and removals, data as of September 30, 2020 (PAS 3000.1638).

# LEGISLATIVE SESSION - FACT SHEET

## Naturopathic Medicine Issues

### TOPIC

Since early 2018, there has been a sustained increase in media attention regarding naturopathic medicine and the College of Naturopathic Physicians of BC (CNPBC). Media coverage has been fuelled by several concerns regarding Naturopathic physicians (NDs) which include: mking anti-vaccination and misleading advertising statements; adverse outcomes from a liquid rhinoplasty procedure performed by an ND; using the titles 'doctor' or 'physician' to promote themselves in a misleading way; and the efficacy of homeopathy and its use to treat conditions outside the ND scope of practice (SoP).

### CURRENT SITUATION

- A registrant is currently involved in a civil litigation suit for adverse outcome resulting from filler injections into the nose (liquid rhinoplasty) by a Vancouver ND.

Personal Information

- Other issues that have raised media attention include the use of terms "general family practice doctors" to define NDs, and misleading claims that naturopathic medicine can prevent or treat COVID-19.

### KEY FACTS

- Naturopathic medicine treats the underlying cause of disease; it supports the natural healing processes of the patient using a holistic approach (e.g., considers physical, mental, emotional, and spiritual aspects of health). NDs provide primary care services and are trained in complementary/ alternative medicine.
- Naturopathic medicine was brought under the *Health Professions Act* (HPA) in January 2000. It had previously been regulated under the former *Naturopaths Act* since 1936. NDs are regulated by the CNPBC in accordance with the HPA, the Naturopathic Physicians Regulation and the CNPBC bylaws.
- The BC Naturopathic Association (BCNA) is the voluntary organization that advocates for the professional and economic interests of NDs. In 2019, there were 637 full practising NDs registered with the CNPBC.[1]
- To become a registered ND in BC, the applicant must have a minimum of 3 years of post-secondary education in liberal arts or sciences; and 4 years post-graduate training from an accredited naturopathic medical school.
- CNPBC recognizes 2 Canadian naturopathic medical schools (1 in BC and 1 in ON) and 5 in the US. All CNPBC registrants must pass the standardized Naturopathic Physician Licensing Examinations. This examination includes biomedical sciences, core clinical science and a clinical elective. The CNPBC requires applicants pass the clinical elective of minor surgery. There are also additional practice certifications, including one for immunization.[2]

**Injection of liquid rhinoplasty**

As of January 1, 2021, the CNPBC announced that registrants would no longer be able to perform liquid rhinoplasty on patients[3], in response to an ongoing lawsuit against a ND for negative outcomes related to a procedure.[4]

**Misleading use of the title's 'doctor' and 'physician'**

- CNPBC bylaws indicate how registrants may use the titles 'doctor' or 'physician,' in association with the terms 'naturopathic' or 'naturopathic medicine.' There is ongoing media attention and complaints about the use of the title's 'doctor' or 'physician' by NDs implying they are medical physicians or medical doctors.
- In November 2018, a complaint was filed with the CNPBC against ND Allison Patton for violating the CNPBC advertising policies by campaigning for Surrey city council as a 'community physician'. In her campaign

[1] Page 9 of Annual Report 2019. https://www.cnpbc.bc.ca/wp-content/uploads/2019-Annual-Report.pdf
[2] https://cnpbc.bc.ca/for-registrants/resources/certification-requirements/
[3] https://cnpbc.bc.ca/notice-to-registrants/
[4] https://www.cbc.ca/news/canada/british-columbia/bc-liquid-rhinoplasty-ban-naturopaths-1.5854092#:~:text=Canada-,'Liquid%20nose%20jobs'%20outlawed%20for%20B.C.%20naturopaths%20over%20concerns%20about,nonetheless%20can%20cause%20serious%20complications.

materials, Patton referred to herself as a *community physician* and outlined her educational history but left out her training in naturopathy.

- In spring 2020, both the College of Family Physicians of Canada and the BC College of Family Physicians wrote to the CNPBC registrar issuing a complaint against Personal Information Personal Information Personal These Colleges asked that the CNPBC take action to prevent registrants from using these terms.
- On August 16 and September 16, 2020 the CNPBC was notified about use of the terms "general family practice doctor" and "family medicine physicians/doctors" to define NDs posted on college registrant's website(s). Registrants were notified by the CNPBC to avoid misleading advertising. Some registrants were investigated. Advice/Recommentations Advice/Recommentations

**Anti-vaccination and misleading advertising statements**

- In 2018, a minority of NDs practicing in BC violated the CNPBC advertising and marketing bylaws by opposing vaccinations and/or promoting therapies outside their SoP (such as providing Complete Elimination of Autism Spectrum Expression (CEASE) therapy to treat autism).
- On May 24, 2018, the CNPBC issued a registrant's notice asking them to ensure compliance with the CNPBC's bylaws on advertising and marketing. The majority of registrants responded appropriately; however, a minority of NDs continued to violate these. The CNPBC further refined and clarified its Guideline on Advertising and Improper Inducements to Treatment to registrants.
- On May 29, 2018, the CNPBC announced changes to their immunization standard including the prohibition of CEASE therapy by its registrants.

Security Concern

- On March 17, 2020, the CNPBC released a public notice that any statement by an ND about the prevention and/or treatment of COVID-19, beyond the information provided by public health authorities, brought to the attention of CNPBC, would be forwarded to the Inquiry Committee for investigation.On January 16, 2021 the CNPBC posted a noticed to registrants indicating: The College expects all registrants to adhere to its Immunization Standard.[6]

Personal Information

Advice/Recommentations

**Use of Homeopathic Remedies**

In April 2018, concerns were raised after a registrant posted to her website about the successful treatment of a 4-year-old boy with aggressive behavior with the homeopathic remedy, Lyssin. A subsequent complaint was filed, and the CNPBC completed an inquiry into the registrant's practice. In November 2018, CNPBC the registrant surrendered her ND license and will not be allowed to reapply as a ND for a minimum of 5 years.

## FINANCIAL IMPLICATIONS

N/A

Security Concern

[6] https://cnpbc.bc.ca/media-release-naturopathic-doctors-and-immunizations/

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
February 11, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Non-Emergency Ultrasound Wait Times in BC

## TOPIC

- Wait times for non-emergency ultrasound exams have been an issue across the province for several years.
- The key factor impacting ultrasound wait times is the long-standing provincial shortage of ultrasound technologists (sonographers).

## CURRENT SITUATION

- Since December 2012, applications for new, expanded or relocated outpatient ultrasound facilities have been under a Medical Services Commission (MSC) moratorium, except for certain procedures which are currently restricted to public hospitals (cardiac-related Doppler Studies and Echocardiography exams).
- The high demand for ultrasound services is likely to increase as the health system works to mitigate wait times that were expanded as a result of the COVID-19 pandemic.
- The current moratorium was scheduled to be lifted June 1, 2020. However, on April 15, 2020, the MSC extended the moratorium until June 1, 2022.

## KEY FACTS

### Moratorium

- In BC, outpatient ultrasound exams are delivered by both public hospitals/health authority facilities and privately-owned community imaging clinics approved by the MSC or their authorized sub-committee, the Advisory Committee on Diagnostic Facilities, to bill the Medical Services Plan (MSP) for provision of approved services.
- The primary reason for the moratorium is the shortage of ultrasound sonographers and the corresponding concern that any expansion in ultrasound facilities, particularly privately-owned facilities, has the potential to draw sonographers away from health authority (hospital) facilities, which could impact essential hospital in-patient and emergency services.

### Wait Times

- The MSC has established a provincial wait time benchmark of 10 working days for provision of "urgent, non-emergency ultrasound". By and large, this benchmark is met across health authority and privately-owned facilities. There is currently no provincial standard benchmark for provision of non-urgent ultrasound.
- Although the Ministry of Health collects wait time information from health authorities for CT and MRI tests, it has not yet expanded this program to encompass ultrasound. There is no standard reporting of ultrasound wait times to the Ministry by either health authority or privately owned facilities at this time.
- Some ultrasound wait time information is gathered on an ad-hoc basis by Ministry staff conducting area-specific research when a facility makes an application to provide and bill MSP for approved ultrasound services.

### Demand

- The volume of general outpatient (MSP billable) ultrasound exams provided in BC grew at an average rate of 4.2% from 2014/15 through 2019/20.[1]
- In 2020/21 April to December, the total number of outpatient ultrasound exams was nearly 903,000. This is a decrease of -13.6% in terms of volume, and a corresponding decrease of -13.3% in terms of MSP billings[2], compared to the previous year.

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[1] Integrated Analytics: Primary Care, Acute Care and Workforce, Health Sector Information Analysis and Reporting Division. Data source: MSP, PAS 2017.0362, Paid date cut-off as of February 15, 2021.

[2] Ibid.

- Sonographers were identified in government's *Labour Market Outlook: 2019 Edition* as a high demand health occupation in BC.[3]
- Recruitment of net new sonographers into the province continues to be a challenge due to a variety of issues, most notably significant compensation competition with the private sector and other jurisdictions, high injury rates and difficulty recruiting to rural areas.

**Sonographer Training**

- The BC Institute of Technology (BCIT) offers a 40 seat, 27-month diploma program with 46 weeks of clinical experience. BCIT has been funded for an additional 8 seats in 2020/21 which will result in 48 seats offered annually through BCIT at steady state. Students train in general or cardiac sonography or a dual general/cardiac option.[4]
- The College of New Caledonia launched a 24-month diploma program in January 2019, with a one-time cohort of 8 students. A full cohort of 16 students was launched in September 2019. This program will continue to offer 16 seats annually each September and train students in general and cardiac sonography.[5]
- Camosun College is also starting a sonography program in May 2021, with a cohort of 16 students annually in the 2-year program.
- It is expected that total potential sonography graduates in BC will reach 80 by 2023 as a result of the new programs and seat expansions.
- Sonography is an eligible profession under the Ministry of Advanced Education, Skills and Training's BC Loan Forgiveness Program, which provides financial incentives for select health-related occupations, by providing loan forgiveness for eligible participants.
- Sonographers working in a designated underserved community can apply for loan forgiveness on the outstanding BC portion of the Canada-BC Integrated Student Loan debt at a rate of up to 20% per year for up to 5 years[6].

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 18, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information Analysis and Reporting Division

[3] Labour Market Outlook: 2019 Editionhttps://www.workbc.ca/getmedia/18214b5d-b338-4bbd-80bf-b04e48a11386/BC_Labour_Market_Outlook_2019.pdf.aspx.
[4] Source: Ministry of Health Diagnostic Medical Sonography Fact Sheet January 2021.
[5] Source: Ibid
[6] Source: https://studentaidbc.ca/repay/repayment-help/bc-loan-forgiveness-program

# LEGISLATIVE SESSION - FACT SHEET

## Number of Health Professional Registrants by College or Registry

### TOPIC

Regulatory and oversight organizations provide information to the Ministry on the number of registrants, actively practising and otherwise.

### CURRENT SITUATION

Regulatory and oversight organizations continue to submit reports annually which provides information to the Ministry on the number of health professionals registered in the province among other things.

### KEY FACTS

- The *Health Professions Act* (HPA) is an 'umbrella' statute that provides a common regulatory framework for self-governing health professions in BC. There are 18 colleges that have delegated authority under the HPA to govern the practice of 25 professions in the public interest.
- In addition to professions regulated under the HPA, one profession (emergency medical assistants) is regulated by a government-appointed licensing board (Emergency Medical Assistants Licensing Board) under the *Emergency Health Services Act*.
- One other occupation (health care assistants) is partially overseen through a provincial registry which is mandatory for health care assistants working in publicly funded facilities but voluntary for health care assistants working in private facilities. This model is currently under review.
- The following table contains the number of health professional registrants based on the information available in the latest published annual reports from each organization responsible.[1]

| Health Professions | Reporting Cycle | Practising Only | Total (all categories incl. non-practising) |
|---|---|---|---|
| Chiropractors[2] | 2019/20 | 1,305 | 1,349 |
| Dental Hygienists[3] | 2019/20 | N/A | 4,182 |
| Dental Surgeons[4] | 2019/20 | Dentists 3,823 / Certified Dental Assistants 6,148 | Dentists 3,951 / Certified Dental Assistants 6,629 |
| Dental Technicians[5] | 2019/20 | Dental Technicians 336 | Dental Technicians 341 / Dental Technician Assistants 479 / Student 14 |
| Denturists[6] | 2019/20 | 271 | 276 |
| Dietitians[7] | 2019/20 | 1,368 | 1,400 |
| Licensed Practical Nurse[8] | 2019 | 13,432 | 13,798 |
| Massage Therapists[9] | 2019 | 5,012 | 5,241 |
| Midwives[10] | 2019/20 | 316 | 405 |
| Naturopathic Physicians[11] | 2019 | 637 | 771 |

[1] Note that these numbers may differ from other numbers produced by the Ministry of Health because these 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 (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://www.chirobc.com/wp-content/uploads/2020/11/CCBC_Annual_Report_2019.pdf

[3] College of Dental Hygienists of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://www.cdhbc.com/Documents/2019-20-Anuual-Report.aspx

[4] College of Dental Surgeons of BC (2020). 2019-20 Annual Report. January 14, 2021 from https://www.cdsbc.org/CDSBCPublicLibrary/2019-20-Annual-Report-printable.pdf

[5] College of Dental Technicians of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://www.cdtbc.ca/_Library/ann_reports/CDTBC_2019-20_Annual_Report.pdf

[6] College of Denturists of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://www.cd.bc.ca/document/6111/AR2019-2020_F.pdf

[7] College of Dietitians of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://collegeofdietitiansofbc.org/wp-content/uploads/2020/06/CDBC_Annual_Report_2019-20_v3.2.pdf

[8] BC College of Nursing Professionals (2020). 2019 Annual Report. Retrieved January 14, 2021, from https://www.bccnm.ca/BCCNM/PublishingImages/Forms/DispForm.aspx?ID=41

[9] College of Massage Therapists of BC (2020). 2019 Annual Report. Retrieved January 14, 2021 from https://cmtbc.ca/wp-content/uploads/2020/07/2019-CMTBC-Annual-Report.pdf

[10] College of Midwives of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://www.bccnm.ca/Documents/governance/annual_reports/legacy_colleges/CMBC/CMBC_annual_report_2019_20.pdf#search=annual%20report

[11] College of Naturopathic Physicians of BC (2020). 2019 Annual Report. Retrieved January 14, 2021 from https://www.cnpbc.bc.ca/wp-content/uploads/2019-Annual-Report.pdf

# LEGISLATIVE SESSION - FACT SHEET

| Health Professions | Reporting Cycle | Practising Only | Total (all categories incl. non-practising) |
|---|---|---|---|
| Occupational Therapists[12] | 2019/20 | 2,668 | 2,772 |
| Opticians[13] | 2019/20 | 846 | 961 |
| Optometrists[14] | 2019 | 848 | 851 |
| Pharmacists[15] | 2019/20 | N/A | Pharmacists 6,269 / Technicians 1,654 |
| Physical Therapists[16] | 2019/20 | N/A | 4,136 |
| Physicians and Surgeons[17] | 2019/20 | 13,257 | 14,007 |
| Podiatric Surgeons[18] | 2019 | 79 | 87 |
| Psychologists[19] | 2019 | 1,257 | 1,346 |
| Registered Nurses[20] | 2019 | Registered Nurses 40,247 / Nurse Practitioners 577 / Licensed graduate nurses and employed student nurses 744 | Registered Nurses 41,753 / Nurse Practitioners 606 / Licensed graduate nurses and employed student nurses 745 |
| Registered Psychiatric Nurses[21] | 2019 | 2,973 | 3,113 |
| Speech and Hearing Health Professionals[22] | 2019 | N/A | Audiologists 306 / Hearing Instrument Practitioners 524 / Speech Language Pathologists 1,343 Total: 1,911 (Note: the total is less than then combined number for each profession as many registrants are registered in two or three professions) |
| Traditional Chinese Medicine and Acupuncturists[23] | 2019/20 | 2,402 | 2,489 |
| Emergency Medical Assistants[24] | 2020 | N/A | Paramedics 7,407 / First Responders 8,182 |
| Health Care Assistants[25] | Dec 2020 | N/A | 38,612 |

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

February 11, 2021 – Mark Armitage, Health Sector Workforce and Beneficiary Services Division

[12] College of Occupational Therapists of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://cotbc.org/wp-content/uploads/COTBC-Annual-Report.pdf

[13] College of Opticians of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from http://www.cobc.ca/my_folders/Annual_Reports/COBC_Annual_Report_2019-2020_-_FINAL.pdf

[14] College of Optometrists of BC (2020). 2019 Annual Report. Retrieved January 14, 2021 from http://optometrybc.com/wp-content/uploads/2020/05/college_optometry_annual_report_2019_May_7_2020.pdf

[15] College of Pharmacists of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from http://annualreport.bcpharmacists.org/ar2020/full-201920-annual-report-pdf

[16] College of Physical Therapists of BC (2020). 2019 Annual Report. Retrieved January 14, 2021 from https://cptbc.org/wp-content/uploads/2020/11/CPTBC-2019-Annual-Report.pdf

[17] College of Physicians and Surgeons of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://www.cpsbc.ca/files/pdf/2019-20-Annual-Report.pdf

[18] College of Podiatric Surgeons of BC (2020). 2019 Annual Report. Retrieved January 14, 2021 from http://www.cpodsbc.org/wp-content/uploads/2019/10/2019-Annual-Report_compressed.pdf

[19] College of Psychologists of BC (2020). 2019 Annual Report. Retrieved January 14, 2021 from http://collegeofpsychologists.bc.ca/docs/CPBC%20Annual%20Report%202019.pdf

[20] BC College of Nursing Professionals (2020). 2019 Annual Report. Retrieved January 14, 2021 from https://www.bccnm.ca/search/Pages/results.aspx?k=ANNUAL%20REPORT

[21] BC College of Nursing Professionals (2020). 2019 Annual Report. Retrieved January 14, 2021 from https://www.bccnm.ca/search/Pages/results.aspx?k=ANNUAL%20REPORT

[22] College of Speech and Hearing Health Professionals of BC (2020). 2019 Annual Report. Retrieved January 14, 2021 from https://cshbc.ca/wp-content/uploads/2020/08/CSHBC-2019-Annual-Report.pdf

[23] College of Traditional Chinese Medicine Practitioners and Acupuncturists of BC (2020). 2019-20 Annual Report. Retrieved January 14, 2021 from https://www.ctcma.bc.ca/media/1928/annual-report-2019-2020.pdf

[24] Emergency Medical Assistants Licensing Board (2020). Retrieved January 14, 2021 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 2020 Year-End Update Report, submitted to the Ministry January 19, 2021. Email.

# LEGISLATIVE SESSION - FACT SHEET

## Nurse in Primary Care Practice

### TOPIC

- A limited pilot initiative, Nurse in Primary Care Practice provides funding to enable the integration of nurses into interdisciplinary teams in family practices in support of the development and implementation of team-based care as a key component of the BC Patient Medical Home (PMH) model, and as a means to improve patient access to primary care, attachment and overall quality of care in proof of concept communities (Kelowna).
- A decision was made to not expand Nurse in Primary Care Practice. The addition of nurses to support team-based care is being implemented through the development and implementation of Primary Care Networks (PCNs).

### CURRENT SITUATION

- As of May 2021, 4 family practices in the Kelowna area have signed contracts and have incorporated a nurse (3 registered nurses (RNs) and 1 licensed practical nurse (LPN)) into their practice utilizing the Nurse in Primary Care Practice approach and associated funding model.
- An evaluation framework is being developed for this proof of concept work. Applied learnings from this initiative will inform the development and refinement of provincial policy to integrate non-physician providers into interdisciplinary teams, as part of PMH implementation across BC.

### KEY FACTS

- The Nurse in Primary Care Practice initiative was developed in an effort to increase practice capacity and net new patient attachment as part of the General Practice Services Committee's implementation of the PMH within PCNs.
- The Ministry provides, under contract with a family practice, block funding to cover the salary, benefits, and other associated costs (such as overhead) for a RN and/or LPN.
- The specific terms of the practice's contract with the nurse (e.g., salary and benefits, vacation, etc.) are determined privately between the two parties.
- Physicians continue to bill fee-for-service for care delivered to patients by the physicians, while nurses are required to complete encounter reporting on the services they provide in order to ensure services are not being paid for more than once. Physicians are prohibited from billing services provided directly by the nurse.
- The initiative aims to expand a family physician's capacity, while maintaining income and improving job satisfaction through a team-based care approach where a RN and/or LPN functions in a complementary role in the family practice.
- It is expected all interdisciplinary team members (including physicians, nurses, medical office assistants, and others) will work to a fully optimized scope of practice within the clinical setting.
- As part of the implementation of the PMH, participating family practices are required to:
    - Work towards the attributes of the PMH;
    - Work with the General Practice Services Committee and the Ministry in determining the practice's attached patient baseline;
    - Develop net additional patient attachment and access targets; and
    - Monitor and measure actual achievement compared to targets.

### FINANCIAL IMPLICATIONS

- The 2019/20 expenditure was approximatively $800,000.
- The budget for 2021/22 is $420,000.

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**Approved:**

May 26, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

May 31, 2021 – Rafter, Brenda obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Nurse Practitioner Primary Care Clinics

### TOPIC

- In 2017 the Ministry of Health launched a transformational team-based primary health-care strategy envisioned to increase patient attachment and access to quality, comprehensive, culturally safe and person-centred primary care services across the province. Team-based primary care will be delivered using a number of different models including Nurse Practitioner (NP) Primary Care Clinics (NPPCCs).
- NPPCCs are a unique service model developed by Nurse Practitioners who will work within a collaborative, team-based environment both within the practice and as part of the local Primary Care Network (PCN)[1].They are an innovative solution to help support communities where a large part of the population has difficulty accessing a regular primary care provider – either a Family Practitioner (FP) or NP.
- The NPPCC model of care became operational in Nanaimo, Victoria, and Surrey in 2020 as part of the approach to improve access to primary care services. Implementation of these initial clinics will allow testing, and evaluation of this new clinic model in BC.

### CURRENT SITUATION

- The Nanaimo NPPCC was announced and opened June 30, 2020.
- The Surrey NPPCC was announced on August 7, 2020 and September 4, 2020 and opened September 8, 2020.
- The Victoria NPPCC was announced on September 18, 2020 and opened September 28, 2020.
- While outside the three NPPCC Ministry initiatives, the NP Flowerstone Family Health Clinic in Qualicum Beach became operational in October 1, 2020. This is a very similar NP model as the NPPCC, and was submitted and approved as part of the Oceanside PCN Service Plan indicating initial support for this model within PCN planning processes.

### KEY FACTS

- When fully operational in Year 3, the NP PCCs will provide longitudinal primary care services delivered by an interdiscipliarny team comprised of:
  - Six Nurse Practitionrs (NPs) working 5.8 FTE clinical (+0.2 FTE Clinical Director) in the Victoria NP-PCC and Surrey NPPCC. 5.5 NPs working 5.3 FTE clinical (+0.2 FTE Clinical Director) and 0.5 FTE GP in the Nanaimo NPPCC.
  - A total of 2.3 FTEs Registered Nurses (RNs – includes relief);
  - One Social Worker; and
  - One Mental Health Worker.
- Three NPPCCs commenced operations in 2020. This will provide an early opportunity to support patient attachment and integration of NP clinics as part of the primary health-care strategy:
  - Nanaimo NPPCC opened June 30, 2020 (1,200 patients registered using the zero- fee billing code as of January 15, 2021).
  - Surrey NPPCC opened virtually August 10, 2020 and was fully operational September 8, 2020 (736 patients registered using the zero- fee billing code as of January 15, 2021).
  - Victoria NPPCC opened virtually August 10, 2020 and was fully operational September 28, 2020 (1,709 patients registered using the zero- fee billing code as of January 15, 2021).
- Current state of population and attachment gap[2], based on the Community Health Service Areas (CHSAs):
  - Nanaimo: population - 108,400 (CHSAs: Nanaimo-Departure Bay; Nanaimo North/Lantzville; Nanaimo-Downtown; Nanaimo-South; Nanaimo West/Rural); a recent collaboration between the Ministry and Island Health estimates an attachment gap of 14,645 (14% of population).

[1] See Primary Care Network Fact Sheet, January 2021.

[2] BC Ministry of Health. ;CHSA PCCI Mapping Tracker – 2020.09.18. PAS 3000.0189.

  - Victoria: population – 151,828, (CHSAs: Victoria/Vic West, James Bay, Oaklands/Fernwood, Oak Bay, Gordon Head); a recent collaboration between the Ministry and Island Health estimates an attachment gap of 23,772 (16% of population).
  - Surrey: population - 76,366 (CHSA: Cloverdale); attachment gap of 14,669 (19% of population)
- It is anticipated over 20,000 patients (6,800 per site) will be attached to a primary care NP over the next three years as a result of this initiative (consistent with NP attachment targets in PCN clinics).
- The Ministry of Health has been working collaboratively with local Divisions of Family Practice (DoFP) and health authorities (HAs) to support integration of the NPPCCs in PCN planning at the community level.
- To support provincial consistency of performance monitoring, reporting requirements will follow the same evaluative criteria as PCN-Patient Medical Homes (PMHs) and Urgent and Primary Care Clinics (UPCCs).

**Background**

Selection Criteria

Nanaimo, Victoria, and Surrey were the sites selected based on the following criteria:

- PCN planning not yet underway (site not included in Year 1 or 2 PCNs).
- Have a significant unattached population.
- Share a vision consistent with the Ministry's commitment to team-based care.
- Committed to working with the local Collaborative Services Committee to ensure that the clinic could be appropriately integrated into the future PCN.

Partnerships/Engagement

- Nanaimo DoFP & Island Health, community organizations, indigenous organizations/groups.
- Victoria DoFP & Island Health; University of Victoria; community organizations; indigenous organizations/groups.
- Surrey/North Delta DoFP & Fraser Health Authority; UBC; community organizations, indigenous organizations/groups.

Engagement with the above groups was important to support acceptance, assess feasibility, and build relationship for eventual PCN planning.

## FINANCIAL IMPLICATIONS

- Annual ongoing operating funding of up to $2.0 million will be provided for each NPPCC when fully operational( See below). One-time funding of $1.7 million was provided to fund initial start-up costs for the three clinics.
- Change management funding of $180,000, allocated for each NP-PCC ($60K/clinic/year x 3 years), is being administered by Nurses and Nurse Practitioners of BC (NNPBC).
- NPs are under service contracts with funds administered by HAs. Registered nurses and allied health providers were hired by health authorities HAs.

| | Nanaimo | Surrey | Victoria |
|---|---|---|---|
| Annual operating funding once clinic is fully operational. | 2,017,494 | 2,000,000 | 2,000,000 |
| One-time Change Management ($60K/year over 3 years) | 180,000 | 180,000 | 180,000 |
| One-time start-up | 495,500 | 754,416 | 445,500 |

**Approved:**

January 31, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 8, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information Analysis and Reporting Division
March 3, 2021 – Kerri Harrison obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Nurse Practitioners

### TOPIC

Nurse Practitioners (NP) are an integral part of the new model of team based primary health care.

### CURRENT SITUATION

There are 3 categories of NPs licensed in BC – Family, Adult, and Pediatric. There are 714 nurse practitioners in BC, 676 of which are practicing.[1]

### KEY FACTS

- NPs, introduced to BC in 2005, are Registered Nurses with additional Masters level education who are authorized to perform the full range of nursing as well as some medical functions including – assessment, diagnosing, prescribing, ordering diagnostic tests, managing common acute/chronic illnesses, referring patients to specialists, and providing leadership, research, and education.
- As independent practitioners, NPs do not require an order from a physician to act and may serve as a patient's primary care and most responsible provider for the continuity and coordination of care. NPs see their own patient panel and work collaboratively with members of the health care team.
- To meet this new demand, the Ministry of Health (the Ministry) worked with the Ministry of Advanced Education, Skills and Training (AEST) to provide one-time funding to support delivery of an additional 30 NP education student seats. Beginning in 2018/19, there were an additional 15 seats at UBC, 5 seats at UVIC and 5 seats at UNBC and an additional 5 seats at UVIC in 2019/20. These new graduates will be available beginning in 2020/21.
- AEST's Budget 2019 expansion provided funding for an ongoing increase of 35 seats, on top of the baseline of 45 seats, starting in 2019/20 (15 seats at UBC, 5 seats at UNBC, and 15 seats at UVic). This will result in a total increase in graduates of up to 35 per year by 2021/22; total seat capacity of 80 first-year seats annually by 2020/21.
- Standards, limits, and conditions for Family, Adult, and Pediatric NPs, are developed through the Nurse Practitioner Standards Committee (NPSC) of BC College of Nurses and Midwives (BCCNM) and can be found in the Scope of Practice for Nurse Practitioners.[2]
- The BCCNM, previously known as the BC College of Nurses and Nurse Practitioners (BCCNP), was established on September 1, 2020 as an amalgamation of BCCNP and the College of Midwives of BC (CMBC).
- NPs are salaried health care providers and do not work in a fee for service model like their Family Physician colleagues. The majority of NPs work as employees of regional health authorities (HAs).
- In 2018, a new remuneration model for NPs was introduced as part of the Primary Care Networks - an independent contract, allowing NPs more flexibility to practice independently in community settings.
- Approximately 60% are working in primary care settings, and 40% are in specialty settings.[3]
- NPs in all settings are required by the Ministry to submit Encounter Records.
- In October 2012, changes to the Hospital Act and Hospital Insurance Act Regulations provided the changes required to enable NPs to admit and discharge patients.
- On December 3, 2015, an updated Nurses (Registered) and Nurse Practitioners Regulation came into effect. On July 26, 2016, NPs gained the authority to prescribe for Medical Assistance in Dying (MAID) and on February 14, 2018 for opioid agonists for the purpose of treating opioid use disorder.
- Legislation that is not inclusive of NPs continues to be a barrier. A comprehensive list of legislative changes required has been compiled by the Nursing Policy Secretariat and a plan for inclusive language in required

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[1] BC College of Nurses and Midwives. (BCCNM) Shinness, Richelle. January 5, 2021. Person Communications.

[2] *Scope of Practice for Nurse Practitioners* (BCCNM, September 2018). Retrieved January 14, 2021 from: https://www.bccnm.ca/NP/ScopePractice/Pages/Default.aspx

[3] Prodan-Bhalla and Scott, *Specialized Services: Nurse Practitioners Collaborating to Improve the Continuum of Care* (BCNPA, December 2017), p. 8. Retrieved January 14, 2021 from: http://bcnpa.org/wp-content/uploads/BCNPA-Specialized-Final-December-21-2017.pdf

legislation is underway. Work is underway to compile all remaining NP legislative barriers into a Misc Act, and an RFL will be forthcoming in Spring 2021.

- To assist in addressing challenges to the current NP program delivery, the Ministry and AEST established the Nursing Education Planning Council (NEPC) in 2018 and the NP Education Working Group in 2019 to review and recommend solutions to current and future challenges associated with NP education. The NEPC is accountable to make recommendations to the Planning Board for Health and Medical Education (PBHME) comprised of representatives from the Ministry and AEST.
- On June 19, 2019, the BCCNM Board approved changes to allow nurse practitioners to provide a medical document for the medical use of cannabis. This change came into effect July 22, 2019[4].

NPs in Primary Care Networks (PCNs)

- The Ministry is currently collaborating with multiple partners to establish an integrated system of team-based primary and community care. PCNs will consist of full-service family practices also known as Patient Medical Homes (PMH) and other models such as Health Authority primary care clinics, and NP-Primary Care Clinics (NP-PCC). Please refer to Primary Care Networks Fact Sheet.
- The Ministry recognizes NPs as an integral part of the primary and community care system and in each of the models listed above, patients can expect an ongoing relationship with a regular primary care provider – an NP or family physician – who is most responsible for their care.
- NP-Primary Care Clinics have been rolled out in 3 communities with high numbers of unattached patients, within Surrey, Nanaimo and Victoria, and are expected to provide longitudinal team-based primary care for 6800 patients in each community. The Nanaimo clinic opened June 30, 2020, the Surrey clinic opened September 8, 2020 and the Victoria clinic opened September 28, 2020. Please refer to NP-PCC Fact Sheet.
- PCNs will maintain strong linkages with HA specialized community service programs for key populations, as well as with the broader health system. Specialized community service program teams may also include NPs to provide care to patients with complex health needs.
- In support of the Ministry's strategic priorities, a review of health sector funding and payment models will include those to support NPs in primary and community care.

## FINANCIAL IMPLICATIONS

- In 2018 Government announced funding of approximately $115 million over three years for 200 new NP positions to support patients in Primary Care Networks and a shift to team-based primary healthcare[5].
- In 2018/19 $15.20M was reallocated from the Nurse Practitioners for BC (NP4BC) initiative to HA base funding for continued NP support.
- In 2019/20 the Ministry provided funding to the health authorities to support NP-Primary Care Clinics. See the NP-PCC fact sheet for additional information including the total funding provided to support the clinics, which includes costs above the NP positions (i.e. administration, setup and overhead).
- As of February 11, 2021 , the Ministry has funded approximately $357.95 million to the HAs for NP positions, including NP-Primary Care Clinics. See table below:

| $ Millions | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HAs - Base Funding | 1.17 | 8.47 | 16.99 | 16.99 | 16.99 | 16.99 | 16.99 | 16.99 | 16.99 | 16.99 | 16.99 | 16.99 | 16.99 | 32.19 | 32.19 | 32.19 | 293.11 |
| HAs - Base NP PCCs | | | | | | | | | | | | | | | 0.63 | 6.14 | 6.77 |
| One-Time Funding | 0.69 | 0.53 | 0.72 | | | 0.12 | 0.06 | 0.25 | | 0.18 | | | | | 1.88 | 0.23 | 4.66 |
| MSP -NP4BC | | | | | | | | 0.45 | 5.21 | 8.50 | 11.96 | 12.80 | 14.50 | - | - | | 53.42 |
| **Total** | **1.86** | **9.00** | **17.71** | **16.99** | **16.99** | **17.11** | **17.05** | **17.69** | **22.20** | **25.67** | **28.95** | **29.79** | **31.49** | **32.19** | **34.69** | **38.56** | **357.95** |

**Approved:**

January 26, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
January 28, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information Analysis and Reporting Division
February 15, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

4 *Legislation Relevant to Nurses' Practice* (BCCNM, May 2020). Retrieved January 14, 2021 from: https://www.bccnm.ca/Documents/regulation/LegislationRelevantNursesPractice.pdf

[5] 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

# LEGISLATIVE SESSION - FACT SHEET

## Nurses' Bargaining Association Collective Agreement

### TOPIC

The Nurses' Bargaining Association (NBA) and Health Employers Association of BC (HEABC) 2019-2022 Collective Agreement.

### CURRENT SITUATION

The NBA and HEABC ratified a new three-year collective agreement on January 21, 2019 under the Sustainable Services Negotiating Mandate.

### KEY FACTS

- The NBA and HEABC Collective Agreement covers 45,907 active employees, or 32,576 Full Time Equivalents (FTEs), and represents an estimated $3.74 billion in annual expenditure on compensation.[1]
- The NBA represents Registered Nurses, Registered Psychiatric Nurses and most Licensed Practical Nurses (LPNs) in BC.
- Most members in the NBA (44,989 or 98% of FTEs) are represented by the BC Nurses' Union (BCNU). Nurses are also represented by the Health Sciences Association, Union of Psychiatric Nurses, Hospital Employees' Union, and BC Government and Service Employees' Union.[2]
- Approximately 87% of nurses in the NBA are employed by the province's six health authorities and 13% work for affiliate organizations, including Providence Health Care.[3]
- The average annual compensation cost for one NBA FTE is estimated to be $114,660, or $58.80 per hour (including the cost of wages and benefits).[4]
- Regular nurses (as defined in the collective agreement) and their employers contribute to a defined benefit pension plan, the Municipal Pension Plan.

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

- The parties ratified a new collective agreement on January 21, 2019.
- 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.
  - 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.

<u>Inclusion of Nurses in Presumptive Disability Legislation</u>

- Regulation which extends the presumption under the *Workers Compensation Act* to employees working in certain occupations came into effect on April 16, 2019 for all nurses regulated by the BC College of Nursing Professionals.
- 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 to access supports and compensation for those illnesses once a formal diagnosis has been made.

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[1] PSEC Public Sector Compensation Annual Forecast 2019 (unreleased)
[2] Ibid
[3] HEABC. (2018). Nurses. Retrieved on September 27, 2018, from: http://www.heabc.bc.ca/Page4310.aspx#.W60fn3tKhpg
[4] PSEC Public Sector Compensation Annual Forecast 2019 (unreleased)

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

The NBA agreement represents an estimated $3.74 billion in annual expenditure on compensation. A 1% negotiated increase to compensation represents approximately $37.4 million.[5]

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**Approved:**
January 26, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[5] PSEC Public Sector Annual Compensation Annual Forecast 2019 (unreleased)

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Cabinet Confidences ; Advice/Recommentations ; Government Financial Information

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Withheld pursuant to/removed as

Cabinet Confidences ; Advice/Recommentations ; Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

## Nursing Community Assessment Service (NCAS) – IENs

### TOPIC

NCAS has been a key strategy to meet health human resource needs in the BC health care system. Integrating Internationally Educated Nurses (IEN)/Canadian Health Care Assistants (HCA) into BC's health workforce will help meet growing labour demand.

### CURRENT SITUATION

Concerns have been raised to the Ministry of Health (MoH) regarding access to and cost of the NCAS assessment. MoH is reviewing the NCAS process, current challenges, and potential solutions to these challenges.

### KEY FACTS

- NCAS operates as a business unit and is accountable to the BC College of Nurses and Midwives (BCCNM) and provides a pathway for IENs Canadian out of province (OOP) HCA graduates, and those returning to practice/requiring a practice review) to gain licensure as a Registered Nurse, Registered Psychiatric Nurse, Licensed Practical Nurse or HCA registration in BC.
- IENs'/Canadian OOP applicants must first apply to the National Nursing Assessment Service (NNAS). After the NNAS reviews the application candidates apply to BCCNM with; (1) NNAS registration number AND an NNAS application number, (2) an NNAS advisory report, and (3) payment. Once applicants meet the BCCNM's English requirements (some may need to provide the BCCNM with English fluency test results) then most applicants are directed to NCAS for the purposes of [1]:
  - Assessing applicants' competency to practice safely and ethically and determine if their competencies are substantially equivalent to those of a BC educated RN, RPN, or LPN.
  - Identifying competency gaps to determine appropriate transitional (remedial) education.
  - Identifying an alternate nursing role for which IENs have demonstrated competencies.
- NCAS Competency Assessment includes three components: Computer-based Assessment (CBA) – 3 hours, Simulation Lab Assessment (SLA)/Oral Assessment (OA) – 3-6 hours in person at a nursing lab available only in Vancouver BC. All 3 components must be completed within one year.[2]
- Results of the NCAS assessment are sent to BCCNM and/or the Registry, and the assessment taker.
- The average time from referral to issuing the assessment report is four months. This can be completed in a more compressed timeframe as assessments are applicant scheduled.[3]
- While the standardized competency assessment has improved standards, there has been a decline in registrations in applicant categories where the NCAS assessment is a required step.[4]
- In 2019 NCAS conducted 669 assessments; 88 dual-tracked, therefore 581 applicants assessed.
- The total number of referrals and completed applications between 2017 and 2019 are noted below[5].

| | Total Applicants | | Completed Referrals / Referrals by Applicant Category | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Internationally Educated Professional | | Out of Province (HCAs only) | | Return to Practice/Reinstatement/ Conversion/Renewal/Re-entry | |
| **Profession** | **Completed Referrals** | **%** | **Completed / Referrals** | **%** | **Completed/ Referrals** | **%** | **Completed/ Referrals** | **%** |
| **HCA** | 604/1496 | **40.37** | 458/882 | 51.9 | *134/*556 | 24.1 | 12/58 | 20.6 |
| **LPN** | 259/371 | **69.8** | 198/292 | 67.8 | 45/54 | 83.3 | 16/25 | 64 |
| **RN** | 871/1105[6] | **78.8** | 871/1105 | 78.8 | N/A | N/A | N/A | N/A |

[1] OOP HCAs follow the Expedited Pathway to become registered in BC (see Health Care Assistant Expedited Pathway Fact Sheet) however, It is expected that a number of Canadian OOP HCA applicants will not meet all of the requirements for the new Expedited Registration Pathway yet they may still qualify for the NCAS competency assessment pathway.

[2] NCAS currently is able to assess for two professions at once, but this may require two referrals.

[3] Rita Parikh, Director, Nursing Community Assessment Service. Personal communications (email). February 20, 2019.

[4] Registry information report, May 14, 2019.

[5] Nursing Community Assessment Service (2020). Briefing Note: Numbers at a Glance.

[6] BCCNM does not identify referral type for RN assessment takers; it is assumed some individuals in this column are also Return-to-Practice applicants.

# LEGISLATIVE SESSION - FACT SHEET

| | Total Applicants | | Completed Referrals / Referrals by Applicant Category | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Internationally Educated Professional | | Out of Province (HCAs only) | | Return to Practice/Reinstatement/ Conversion/Renewal/Re-entry | |
| **RPN**[7] | 10/23 | **43.47** | 9/20 | 45 | N/A | N/A | 1/3 | 33.3 |
| **TOTAL** | **1,744/2295** | **75.99** | **1536/2299** | **66.8** | **179/610** | **29.3** | **29/86** | **33.7** |

*Since January 2018 when Canadian-educated HCA applicants began taking NCAS HCA.
*Barriers to registration for IEHPs includes; the timeline for completion of the registration process as well as financial barriers (*See IEHP Supplement)

- MoH has approved an expedited pathway for qualified Canadian trained HCAs, effective January 15, 2020; those eligible for the expedited pathway will not be required to complete the NCAS assessment.

COVID Impact

- In March 2020 NCAS temporarily closed activity due to the COVID-19 pandemic and re-started again in August 2020. NCAS has been working on restructuring assessments in order to address the growing waitlist since closure.
- The Nursing Policy Secretariat (NPS), BCCNM, Nurses and Nurse Practitioners of BC (NNPBC), NCAS, and the BC Nurses Union (BCNU) have reviewed the application and employment process for IENs, and collectively identified collaborative approaches to streamline the IEN process.
- MoH is currently evaluating the feasibility of a suite of short and longer term options to remove barriers to IEN registration in BC.

## FINANCIAL IMPLICATIONS

- In 2014/15 and 2015/16, Health Canada provided a total of $2.34 million to develop and pilot the NCAS project as part of Health Canada's Internationally Educated Health Professionals Initiative.[8]
- MoH provided $1.4 million to the Provincial Health Services Authority (PHSA) to support NCAS for fiscal years 2016/17 and 2017/18 (total $2.8 million).
- In 2017, NCAS applicant fees was $500 for all professions. In January 2018, fees increased for all professions: HCAs - $800[9] and IENs (RN/LPN/RPN) - $2,000.
- Neither MoH nor PHSA provided any funding to support NCAS after 2017/18.
- In 2019/20, MoH established an agreement with the Health Employers Association of BC, who manage health professional's recruitment services through Health Match BC which included $1 million in funding over three years to support NCAS bursaries for HCAs. This funding is separate from NCAS operations.
- Through the MoH's HCA Recruitment and Retention Strategy, Health Match BC bursary funding will support HCA applicants still requiring NCAS assessment and remedial education.

Government Financial Information

- NCAS fees for HCAs will increase from $800 to $2,000 on January 15, 2021[10]; Government Financial Government Financial Information in a move towards attaining cost recovery for operations.

**Approved:**
February 14, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
Feburary 21, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[7] RPN totals also include two applicants who were pass-through referrals from CRPNA in Alberta.
[8] IEHP Initiative-BC HC Contribution Agreement 6804-15-2010/10570323 signed August 2, 2011; and Shared Cost Arrangement #2014-192 with CRNBC
[9] http://www.ncasbc.ca/Fees/Pages/default.aspx Accessed June 8, 2020.
[10] Rita Parikh, Executive Director, Nursing Community Assessment Service. Personal Communication (e-mail to Joanne Maclaren et al), November 10, 2020

Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

## Nursing License Fees

### TOPIC

Nurses have raised concerns about the licensing/registration fees they pay to the BC College of Nurses and Midwives (BCCNM). An online petition asks government to waive nurses' licensing fees and require employers to absorb the cost of nurses' liability insurance, in lieu of Medical Services Plan fee coverage. [1]

### CURRENT SITUATION

- BCCNM licensing/registration fees for nurses for 2021/22 are increasing, but remain on par with, or less than, licensing fees paid by other regulated heath professionals in BC.
- Effective March 1, 2021, BCCNM is transferring administration of Canadian Nurses Protective Society (CNPS) professional liability protection/insurance to Nurses and Nurse Practitioners of BC (NNPBC), the provincial nursing association, in an effort to continue BCCNM's focus on regulatory work. Total costs for licensing, insurance, and association membership will increase or decrease slightly for an individual nurse depending on the option chosen by the nurse.

### KEY FACTS

- BCCNM regulates nursing professionals and midwives under the authority of the *Health Professions Act*. The regulatory college operates at arm's length from government and is responsible for governing its registrants in accordance with the Act, the professions' Regulation, and the BCCNM bylaws.
- All regulated health professionals in BC, including nurses, pay fees to their regulators for license to practice.
- Licensing fees are set by regulatory college boards. Regulatory colleges are not funded by government.
- Licensing fees are set out in regulatory college bylaws, for which the college is responsible. While college bylaws are filed with the Minister, the Minister does not approve bylaw content. Most bylaw changes are subject to a three-month notice period (an opportunity for feedback). BCCNM bylaws related to nurses professional liability insurance were publicly posted from August 2, 2019, to November 2, 2019.
- Licensing is important to patient safety because it ensures regulated health professionals are competent.
- The role of the Ministry of Health is to monitor the general functioning of the regulatory colleges to ensure they are complying with all applicable legislative requirements and have mechanisms in place to carry out their mandate to protect the public from incompetent, impaired or unethical practice.

<u>2021/22 BCCNM Licensing/registration fees for practicing nursing registrants</u>

- 2021/22 licensing fees will cover 13 months to shift the renewal period to February/March 2022.
- Registered nurses (RNs) and registered psychiatric nurses (RPNs) will pay $558.36 for 13 months of registration. This includes a fee increase of $14.60 or 3%, and a one-time cost of $43.71 for an extra month.[2]
- Nurse practitioners (NPs) will pay $803.88 for 13 months of registration. This includes a fee increase of $21.90 or 3%, and a one-time cost of $62.93 for an extra month of registration.[3]
- Licensed practical nurses (LPNs) will pay $514.80 for 13 months of registration. This includes a fee increase of $47.45 or 11%, and a one-time cost of $40.30 for an extra month of registration.[4]
- Registered dietitians pay $600[5] and registered speech pathologists pay $750 for annual registration fees.[6]
- Nurses who are BC Nurses' Union (BCNU) members and are covered by the Nurses' Bargaining Association collective agreement may be eligible for a $215 reimbursement of their BCCNM registration renewal fee.[7]
- BCCNM reports registration fees for nurses reflect the cost of regulation, which has increased in recent years to respond to: more serious and complex complaints; new or more complex entry-level nursing education programs to review; the development of new registration exams; and more complex registration files.

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[1] Change.org petition: https://www.change.org/p/ministers-adrian-dix-and-harry-bains-stop-gouging-healthcare-workers
[2] BCCNM: https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=214
[3] BCCNM: https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=213
[4] Note, this is a $17.55 increase over what LPNs paid in 2020-2021 for 14 months of registration. BCCNM: https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=212
[5] College of Dietitians of BC https://collegeofdietitiansofbc.org/wp-content/uploads/2020/04/1_1_2_4_200415_Sch_D_Fees.pdf
[6] College of Speech and Hearing Health Professionals of BC: https://cshbc.ca/registrants/registration-renewal/
[7] BCCNM: https://www.bccnm.ca/bccnm/Announcements/Pages/Announcement.aspx?AnnouncementID=214

Liability Insurance (Professional Liability Protection)

- Liability insurance for regulated health professionals is critical for patient and practitioner protection.
- Liability insurance/professional liability protection is a requirement for practicing registration with BCCNM.
- Transferring insurance administration impacts practicing RNs, RPNs, NPs, and employed student registrants.
- Now, as in other provinces, nurses in BC can purchase liability insurance as part of their membership with their professional association, which gives them access to a lower CNPS group insurance rate. An RN, RPN or NP who chooses not to be a member of the provincial nursing association can obtain CNPS liability insurance at the individual rate or in certain very limited specific situations from another provider (if BCCNM requirements are met).

| **Fees for RNs and RPNs** (practicing)[8] | **2020/21** (12 months) | **2021/22** (13 months, with NNPBC association membership) | **2021/22** (13 months, no NNPBC association membership) |
|---|---|---|---|
| BCCNM Registration | $ 500.05 | $ 558.36 | $ 558.36 |
| CNPS Liability protection | $ 50.40 | $ 54.60 | $ 164.85 |
| Association membership | $ 129.83 (optional) | $ 54.60 | N/A |
| **Total** | **$ 550.45** (no association membership)<br>**$ 680.28** (with membership) | **$ 667.56** | **$ 723.21** |

| **Fees for NPs** (practicing)[9] | **2020/21** (12 months) | **2021/22** (13 months, with NNPBC association membership) | **2021/22** (13 months, no NNPBC association membership) |
|---|---|---|---|
| BCCNM Registration | $ 719.05 | $ 803.88 | $ 803.88 |
| CNPS Liability protection | $ 167.48 | $ 181.44 | $ 375.38 |
| Association membership | $ 129.83 (optional) | $ 54.60 | N/A |
| **Total** | **$ 886.53** (no association membership)<br>**$ 1016.36** (with membership) | **$ 1,039.92** | **$ 1,179.26** |

- Nurses also pay BCNU dues at 2% of their gross straight time pay, dues are not calculated on overtime or on some premiums and allowances.[10] For example, a Level 4 RN/RPN would pay between approximately $1,647 and $2,019 in annual union dues depending on which step (1-9) in the wage grid the nurse is employed in.[11]
- The Cayton report,[12] which made suggestions to modernize the regulatory framework, suggested regulatory colleges separate themselves from professional associations, to ensure the associations are not accorded special privileges or have the ability to influence college decision-making.

Reinstatement Fees and Process (following Maternity and other Return to Practice)

- In 2020/21, the BCCNM (then the BC College of Nursing Professionals) return to work/reinstatement fee for RNs, RPNs, and NPs returning to practice increased to reflect the work associated with assessing an application. The fee was $100 (+GST) in 2019/20; $225 (+GST) in 2020/21; and is $230 (+GST) for 2021.[13]
- Prior to September 1, 2020, RNs and NPs seeking reinstatement were asked to attest to their practice hours, while all other nurses were required to verify practice hours. The September 1, 2020, bylaws for the newly amalgamated BCCNM aligned reinstatement requirements across nursing designations.

## FINANCIAL IMPLICATIONS

N/A

**Approved:**
February 11, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[8] BCCNM February 3, 2021
[9] BCCNM February 3, 2021
[10] BCNU: https://www.bcnu.org/member-services/current-members/your-union-dues
[11] BC Ministry of Health, Health Sector Workforce and Beneficiary Services Division, February 3, 2021
[12] BC Government: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/cayton-report-college-of-dental-surgeons-2018.pdf
[13] BCCNM January 18, 2021

# LEGISLATIVE SESSION - FACT SHEET

## Nursing Practice Education and Transition Model

### TOPIC

A new, innovative baccalaureate (BSN) nursing practice education and transition to practice model is required to ensure new nursing graduates are effectively prepared to meet increasingly complex care requirements; to reduce high turnover in the nursing workforce; and to address nursing faculty shortages.

### CURRENT SITUATION

The governance structure of the Nursing Education Practice Council (NEPC) transitioned in November 2020 to a Ministry of Health (MoH) and Ministry of Advanced Education and Skills Training (AEST) co-chair shared accountability. A project structure is in place with members from nursing practice, education, union, regulatory and association to support the work. The learning pathways (perioperative, rural and remote and acute complex) and new graduate transition working groups have been launched in December 2020.

### KEY FACTS

- Health leaders in BC recognize increasing acuity and complexity of patient care has presented substantive challenges to the development, recruitment, and retention of the nursing workforce.
- The demand for nurses prepared for what has been traditionally considered "specialty" nursing practice (e.g., perioperative, critical care) is increasing. In 2016, approximately 44% of BC's nurses worked in more complex or acute settings and this has grown upwards of 50 to 60% in some health authorities.[1]
- Currently, there is a lack of alignment between entry-level educational preparation and expectations in practice, particularly in more acute/complex care settings. As a result, new graduate nurses often struggle to balance the best practice/professional practice standards taught in nursing education with demands of challenging practice environments.
- First year turnover rates for newly graduated nurses in BC is 13%, with an approximate 191 newly graduated nurses (NGNs) exiting the profession each year.[2]
- Nurse turnover (defined as job movement within an organization) is estimated at 17% and 33% in the first and second years of practice respectively.[3] The evidence states that turnover rates can be positively impacted by a supportive transition program during the first 12 months of employment.[4]
- Nursing schools in BC have experienced issues related to workforce shortages in nursing faculty. Shortages are anticipated to increase with 40% of nursing faculty in Canada 55 years or older.[5] Faculty shortages have implications for training capacity to deliver existing FTEs, and future increase in training spaces.
- The cost of replacing a registered nurse (RN) is estimated to range from $17,000 to $20,000, reflecting the expenses associated with filling temporary vacancies, hiring and orienting new staff.[6] This does not include the investment cost by AEST for the RN's training seat.

<u>Nursing Practice Education and Transition Model Overview</u>

The new model will address retention and turnover rates and effectively support NGNs and nursing faculty. The work will entail the following: Transform the final year and/ or final practicum of nursing education to prepare RN graduates for workforce needs; create a sustainable transition model to support the newly graduated RNs; and develop a robust strategy for educator/ faculty development, including exploration of new roles.

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[1] BC Ministry of Health. Byres, David. (2018). Presentation on Specialty Nursing.

[2] Chachula, Kathryn, Myrick, Florence, and Yonge, Olive. (2015). Letting go: How newly graduated nurses in western Canada decide to exit the nursing profession. Nurse Education Today, 35, 912-918.

[3] International Centre on Nurse Migration, International Council of Nurses (2018) *Policy Brief: Nurse Retention*. Retrieved from: www.icn.ch/sites/default/files/inline-files/ICNM%20Nurse%20retention%20FINAL.pdf

[4] Edwards, Deborah. (2019). *A systematic review of the effectiveness of strategies and interventions to improve the transition from student to newly qualified nurse: An Update Systematic Review Protocol*. Joanna Briggs Institute Database of Systematic Reviews and Implementations, 17(2), 157-163.

[5] Canadian Association of Schools of Nursing. (2018). Survey Report of Faculty Shortage in British Columbia Schools of Nursing. Unpublished report.

[6] Duffield, C. M., Roche, M. A., Homer, C., Buchan, J., & Dimitrelis, S. (2014). A comparative review of nurse turnover rates and costs across countries. Journal of Advanced Nursing, 70(12), 2703–2712. Retrieved on October 1, 2019 from: https://doi-org.ezproxy.library.uvic.ca/10.1111/jan.12483

Details include:

1. **Learning Pathways:** Baccalaureate nursing students enter a learning pathway in their final practicum that aligns with their practice area of interest with potential for regular employment after graduation aligned with health system workforce needs. Students/ NGNs would be supported by dedicated resources that are available in the clinical setting. In some instances, the learning pathway would be largely completed by graduation while for more complex care settings, the pathway may continue beyond graduation.
2. **Provincial Transition Support Program:** All new graduates would be hired and supported beyond graduation through a provincial transition to practice program that would support NGNs from the end of their undergraduate program practicum up to 12 months post hire. Key elements of the program are supernumerary time, transition theory, and mentorship.
3. **Hybrid Faculty Educator Roles:** New hybrid roles that span academic and practice sectors along with faculty mentorship support would be employed to support faculty and clinical educators to effectively implement the model and to address the faculty workforce shortage.

Background

- The Nursing Policy Secretariat's (NPS) 2018 Priority Recommendations report[7] recommendations for nursing education were endorsed by the MoH and AEST. The recommendations include:
    - Future discussion of entry to practice education should consider input from practice, education, operations, regulation, and government.
    - The NPS will bring representatives from the practice, operational, education and government sectors to establish an educational model for the future that considers requirements in both acute, community, and primary care sectors.
- In June 2018, under the leadership of the MoH and AEST Joint Planning Board for Health and Medical Education (PBHME), NPS launched a review to identify changes to modernize and strengthen the efficiency, effectiveness and sustainability of BSN undergraduate nursing education and NGNs' transition to practice.
- The NPS established the Nursing Education Planning Council (NEPC), a health and education collaborative structure which completed the review work resulting in a recommended model (see model overview above). The NEPC report and proposal was endorsed by the PBHME on August 27, 2019.
- The NEPC submitted a proposal to AEST for a Work Integrated Learning grant to begin the development of the model. The grant was approved in June 2020. [8] The University of Victoria is the grant administrator.

## FINANCIAL IMPLICATIONS

The Ministry is currently reviewing and assessing the proposed recommendations/strategy. The Work Integrated Learning grant of $290,000 is funded solely by AEST – refer specific questions to AEST.

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**Approved:**

January 26, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
January 28, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[7] BC Ministry of Health. Byres, David. (2018). *Nursing Policy Secretariat Priority Recommendations Report*. Retrieved on October 1, 2019 from: www.health.gov.bc.ca/library/publications/year/2018/nursing-policy-consulation-report-Jan24-2018.pdf
[8] Email communication from Brian Train, Education Officer, AEST June 2, 2020.

# LEGISLATIVE SESSION - FACT SHEET

# OAG Independent Audit of the Recruitment and Retention of Rural and Remote Nurses in Northern BC

## TOPIC

Progress update on the 9 recommendations outlined in Office of the Auditor General's (OAG) 2018 report - *An Independent Audit of the Recruitment and Retention of Rural and Remote Nurses in Northern B.C.*

## CURRENT SITUATION

The Ministry of Health has worked closely with Northern Health (NHA) and key partners to coordinate the implementation of the OAG recommendations. Although NHA has made significant progress; they note that since the onset of the pandemic beginning in March 2020, significant ongoing shifts in critical priorities, timelines and redeployment of staff to meet new and immerging needs have been required.

## KEY FACTS

Objective of the audit was to determine the effectiveness of NHA's health human resources (HHR) plan to recruit/retain registered nurses (RNs) and nurse practitioners (NPs) in rural and remote positions.

| # | Audit report recommendations | NHA Action Plan Progress Update January 2021 |
|---|---|---|
| 1 | NHA, to create a more effective HHR plan, consider broad range of factors, including community characteristics, population health needs, scope of practice, stakeholder input and current circumstances. | **Fully implemented:**<br>Workforce Planning Toolkit implemented at departmental levels; workforce planning fully implemented (Dec. 21, 2018); HHR Plan delivered (April 2019). Recommendations from NH executive and Board integrated into HHR Plan and approved (March 2020). HHR plan incorporated tracking of strategic actions and metrics that will be measured and updated on an annual basis (update in progress Feb 2021 including new priority professions that have been identified). Profession specific plans will be reviewed and updated annually.<br>**Contributing actions:** April 2018: Nurse Practitioner (NP) recruitment transitioned to Medical Affairs to align NPs with physicians; May 2018: Focus groups with NHA staff and leaders; Professional Practice-Nursing; North West Leadership Forum; June 2018: North East Integrated Primary Care. |
| 2 | NHA work with communities and the provincial government to expand temporary and long-term affordable housing options in northern rural and remote communities. | **Fully Implemented:** MoH funding in 2017, via provisions in the Nurses Bargaining Association collective agreement to pilot Introductory Housing program. Housing secured June 1, 2018. Fort St. John housing confirmedin 2018.. Northern Health continues to work with local communities, local governments, and the province are ongoing to address additional housing needs in various communities.<br>**Fully Implemented.** Partnering with communities regarding recruitment/retention initiatives, e.g., Peace River Regional District to build scholarship program to support recruitment and expand workers' skills. In 2021 Northern Health worked with a community in the Northwest to support a similar program. NH Recruitment Services meets bi-annually with FNHA to identify collaboration on housing options. |
| 3 | The University of Northern BC and the Ministries of Health and Advanced Education work with NHA and other key stakeholders to analyze the distribution of nursing education programs in the north and implement changes to address regional recruitment challenges. | **Fully Implemented.** NHA, UNBC and local community colleges continue to work together to maximize educational opportunities and clinical practice for nurses. UNBC's Rural Nursing Certificate Program is a key educational component. NH also continues to collaborate with UNBC to provide student access to locally developed specialty education courses in Prince George (Pediatrics, NICU and perinatal). NH has also been working closely with UNBC to develop a pediatric specialty course.<br>June 2018: Implemented UNBC School of Nursing/ NHA Clinical Placement Working Group. August 2018: Implemented NHA Education Program Planning Collaborative.<br>2019-current: NH working collaboratively with northern PSIs to increase practical nursing cohorts. March 2020: Implemented bi-monthly NH/ UNBC School of Nursing meeting.<br>Sept 2020: NH hired Recruiter, Academic Partnerships (one-year term) to liaise with Indigenous partners and communities, community-based adult and youth employment services and post secondary institutions to identify opportunities and individuals from non-traditional populations interested in health care careers.<br>**Partially Implemented:** January 2021: Pilot project initiated: UNBC 4th year nursing students enrolled in specialty education programs pathway.<br>**Substantially Implemented**:<br>June 2019: Ministry of Health had engaged in discussion on a multiyear agreement for $1.1M to launch the first Nursing degree program in the North East.[1] Funding of $114K was provided for 2019/20. No further funding has been finalized as program start has been delayed from Sept. 2020 to Sept. 2021. Program to be delivered by UNBC in Fort St John, in partnership with Northern Lights College and NHA; 32 students at |

[1] Ministry of Advanced Education, Skills, and Training. June 7, 2019. *News release: Nursing degree program coming to the Northeast.* Retrieved from: https://news.gov.bc.ca/releases/2019AEST0070-001195, accessed January 21, 2020.

| # | Audit report recommendations | NHA Action Plan Progress Update January 2021 |
|---|---|---|
| | | full capacity and will admit 16 students for Sept 2021 launch. Previously, students travelled to Prince George or Terrace. Now, students able to study closer to home.[2] |
| 4 | NHA continue to work with the BC Nurses' Union to develop and implement new recruitment and retention programs and tools for RNs in the north. | **Fully Implemented:** NH received Ministry funding in 2017 via provisions in the NBA collective agreement to pilot an Introductory Housing program to offset housing challenges in northern communities. NHA's HHR Plan will help determine opportunities to partner with BCNU on recruitment/retention strategies. Implemented a Travel Nurse Pool: nurses can be assigned to various worksites within the NHA.<br>February 2020: The Strategic Nurse Staffing Committee meets on a monthly basis to consult on health authority level nurse workforce planning including trends, activities and initiatives related to the following: Regularization of hours, recruitment and retention strategies, regular relief positions, other relief needs, nurse education and training (including specialty nursing), seasonal strategies, annual vacation, and other organization-wide staffing matters. |
| 5 | NHA develop recruitment strategy (RN) with clear goals and performance measures that guide its activities and enable it to assess progress. | **Fully Implemented**: Developed a recruitment strategy for nurses and other priority healthcare providers. Established work plan incorporating key target dates for delivery of Recruitment Strategy. Identified and implemented key performance indicators and recruitment metrics. |
| 6 | NHA establish clear responsibility for all aspects of its recruitment and hiring processes, including oversight. | **Fully Implemented:** Feb. 2018, Regional Director, Recruitment & Retention position created.<br>**Fully Implemented:** Recruitment meets with senior leaders to review all current postings.<br>**Fully Implemented:** Refreshed HR training, processes, resources for managers, recruitment manager orientation training; revised and enhanced NHA recruitment training workshop curriculum; manager orientation training continued. |
| 7 | NHA ensure that all hiring managers receive comprehensive training on their recruitment and retention roles and responsibilities. | **Fully Implemented:** Developed leadership and management pathway as a key nurse retention strategy. Dialogue initiated to collaborate on Leadership Pathway development with key NHA stakeholders. Additional leadership programming to be endorsed.<br>**Fully Implemented:** Expanded access to leadership and management training including additional cohorts of Core LINX introductory leadership course: cohorts were increased from 2 to 4 for 2018/19 fiscal; full cohort of Experience LINX offered Feb. 2019. In April 2019 NH returned to two Core Linx cohorts per year. Core LINX facilitator development underway: 2 new facilitators added to existing cohort of 3.<br>February 2020: NH has identified expectations for supervisors and managers of nursing staff focused on workforce sustainability to ensure service continuity and delivery to support recruitment and retention. |
| 8 | NHA develop and implement a standard orientation process for RNs that can be adapted to meet the needs of diverse sites. | **Substantially Implemented:** Implementation plan for workshops/supports and at sites for newly graduated (NG) nurses. Updated Transition Workshops. NGs funded to attend. New Graduate Transition Program Coordinator (one-year term) – to be evaluated after 6 months (approx. Sept 2021).<br>**Fully Implemented:** Community Phased education complete; ongoing review/ refresh. Community IPT managers dashboard developed for leadership to track individual and team-based education to support ongoing staff development/ quality service delivery.<br>**Substantially Implemented:** Completed phase 2 and 3 LTC CAPE tools. CAPE tools are available on Learning Hub and OurNH.<br>Completed phase 2 and 3 Specialized Services CAPE tools development. These will be available on the Learning Hub by December 31, 2021<br>Managers Dashboard is anticipated to go live by the end of September 2021.<br>**Partially Implemented:** Phase Two and Three for Specialized Services developed along with Cape tools (review completed Feb 1, 2021); entered in a LH shell (fiscal YE 2021). ITS to work on developing a Managers dashboard (anticipated by Summer 2021).<br>**Not Implemented Yet:** Acute care phases in the queue for Fall 2021. |
| 9 | NHA develop an RN retention strategy with clear goals and performance measures that guide its activities and enable it to assess progress. | **Substantially Implemented:**<br>Health Human Resources Strategy (HHRS) completed (inclusive of targets/ metrics for RN recruitment and retention; updated on an annual basis). June 2019: Psychological Health and Safety (PHS) in the Workplace Working Group to look at PHS hazards and provide guidance and recommendations on the implementation of the PHSW Standard. Membership includes all major health care unions, operational leadership representatives, HR/organizational development, Doctors of BC, local physician, and medical affairs.<br>Communications plan developed to raise awareness/ and understanding of workplace PHS (initial introduction to the PHS Standard; monthly status update on the 13 workplace factors (for 13 months). Also, staff and leadership COVID-19 related memos have been circulated.<br>Employee engagement survey (four-year cycle as per Accreditation Canada expectation); hasmoved to the Guarding Minds at Work survey (aligns with PHSW Standard). |

## FINANCIAL IMPLICATIONS

N/A

[2] Ministry of Advanced Education and Skills Training. Werelely, Neil. September 14, 2020. Personal communications.

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
February 15, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 8, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## 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 four pathways to registration and licensure in BC.

### CURRENT SITUATION

- Timelines for Medical Council of Canada (MCC) national examinations have been impacted as a result of COVID-19. The national regulatory colleges have been informed of these changes. The MCC, responsible for assessing IMGs seeking to practice medicine in Canada, continues to closely monitor the COVID-19 situation and potential impacts on future exams. The MCC is exploring the option of virtual delivery for Objective Structured Clinical Examinations to mitigate against the challenges of in-person exam delivery due to the pandemic.
- The 2020 UBC Clinical Assessment Program (CAP) will be delivered virtually in January 2021.

### KEY FACTS

- Medical education varies widely among internationally educated physicians 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 College of Physicians and Surgeons of BC (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 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.
- In general, there are 4 pathways to registration and licensure in BC:
  1. a) IMGs who have completed their family medicine residency training in an approved jurisdiction acceptable to 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.
     b) For IMGs who have completed specialty training (i.e., internal medicine) 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.
  2. 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 for more detail**).
  3. 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 positions; 6 general

specialty positions) through the Canadian Resident Matching Service (CaRMS) (**See IMG-BC Fact Sheet for more detail**).

4. In 2020, CPSBC drafted new bylaws to introduce a restricted "associate physician (AP)" class of registration for practitioners who are not eligible for a full or provisional license. Once fully established, this pathway will allow individuals with a minimum of two years accredited postgraduate training in a surgical or medical specialty to work under supervision in structured team-based specialty care settings to increase capacity and service delivery **(see AP Fact Sheet for more detail)**.

Postgraduate Medical Education (Residency)

- Entry into UBC PGME Programs is highly competitive. In 2020, 1,435 IMGs applied nationally for 325 IMG-dedicated residency positions through the CaRMS.[1]
- 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, including the:
    - Medical Council of Canada Qualifying Exam Part I (MCCQE 1): a summative examination assessing critical medical knowledge and clinical decision-making ability;
    - National Assessment Collaboration Exam: an objective structured clinical exam which is a series of mock clinical situations with standardized patients in designated stations.
- IMGs seeking to match to a residency position in BC are required to participate in UBC's one-day CAP. The CAP provides a transparent and equitable process to assess candidates' past 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 are required to 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 for a provisional registrant.
- An applicants can request a review of their registration decision by the Health Professions Review Board.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
January 31, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[1] CaRMS (2020). R-1 Data and Reports: 2020 R-1 Match Reports Table 1 and Table 14. https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 14, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Pharmacist Injection and Intranasal Drug Administration

### TOPIC

- Pharmacist drug administration by injection and intranasal route is currently limited to immunization-only.
- This limitation is specified in the College of Pharmacists of BC's (CPhBC) standards, limits and conditions in bylaws under the *Health Professions Act* (HPA).
- The CPhBC Board has approved the removal of this limitation in their bylaws, which would have significant impacts on how health care is delivered in this province.

### CURRENT SITUATION

- The proposed bylaws amendment would give BC pharmacists broad drug administration scope of practice,

Advice/Recommentations

### KEY FACTS

- In October 2009, the Pharmacists Regulation of the HPA was amended to enable pharmacists to administer drugs by injection (and subsequently amended to include by intranasal route).
- The intention was to enable pharmacists to provide immunization services in response to Influenza H1N1; however, the regulatory amendment was written in a way that allows pharmacists to administer any Schedule I, IA or II drug, and the restriction to 'immunization-only' was specified in the CPhBC's bylaws (in the 'Limits' section).
- In accordance with the Pharmacists Regulation, the CPhBC established the Drug Administration Committee (DAC) to develop, review and recommend the standards, limits and conditions for pharmacist injecting.
- The DAC membership includes 4-7 members (at least 1 full pharmacist, 1 medical practitioner, 1 registered nurse and 1 Ministry representative (Pharmaceutical Services Division represents the Ministry).

Advice/Recommentations

- During 2018, the DAC reviewed the restrictions on pharmacist drug administration and surveyed all pharmacist regulators in Canada that grant broader injection authority beyond immunization.
- In February 2019, on recommendation of the DAC, the CPhBC Board directed the Registrar to draft bylaw amendments that would:
    - remove the current restrictions on pharmacist injection and intranasal administration of drugs or substances (with the exception of Schedule IA drugs);
    - restrict pharmacists from injecting for cosmetic purposes; and
    - retain the current age restrictions on pharmacist drug administration (i.e. no injection to a child under 5 years old, nor by intranasal route to a child under 2 years old).

Advice/Recommentations; Government Financial Information

Cabinet Confidences; Government Financial Information

- In February 2020 the Ministry's priority turned to regulatory modernization and in April to COVID-19 work.

Advice/Recommentations; Government Financial Information

- The CPhBC Board approved-in-principle the bylaws amendments at its November 22, 2020 meeting.

Advice/Recommentations; Government Financial Information

- The review of pharmacist injection authority has been initiated by the health profession Advice/Recommentati

Advice/Recommentations

Advice/Recommentations The expansion of health professions' scope of practice is normally driven by government to address specific needs or to realize certain benefits within the health care system.

- As time allows over the coming months, the Ministry intends to take more of a lead role on key pieces of the work, including internal consultation to determine whether there is an identified need to adjust the way in which patients receive regular and/or intermittent injections, and identify barriers and potential solutions.

## FINANCIAL IMPLICATIONS

The Ministry has not conducted a financial analysis of the implications associated with expanded pharmacist drug administration authority.

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**Approved:**

May 27, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
May 31, 2021 – Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Physician Benefits

### TOPIC

Physician benefits are subject to negotiation as part of the Physician Master Agreement (PMA). In 2021/22, as prescribed through the 2019 PMA, physicians will receive a maximum of $224.685 million from provincially funded benefit plans, administered by the Doctors of BC.

### CURRENT SITUATION

Current physician benefit programs funded through the PMA are:

Canadian Medical Protective Association (CMPA) Rebate Program[1]

The CMPA provides physicians with legal and risk management assistance related to their medical practice. The CMPA rebate program provides eligible physicians with a partial reimbursement of their CMPA expense. CMPA rebate base funding in 2021/22 is $60.289 million.

Continuing Medical Education (CME)[2]

- A yearly allotment of funding used to assist physicians with eligible professional education expenses.
- In order to maintain their professional credentials with the BC College of Physicians & Surgeons, each physician is required to participate in a prescribed minimum level of professional education per year. Annual base funding in 2021/22 is $9.725 million.

Contributory Professional Retirement Savings Plan (CPRSP)[3]

Provides funding to physician retirement savings plans through (i) a basic benefit that does not require matching contributions by physicians, and (ii) a length of service benefit which is based on the number of years a physician has practiced in BC, which may be paid into a Tax Free Savings Account. Annual base funding in 2021/22 is $92.37 million.

Parental Leave Program (PLP)[4]

Provides up to 17 weeks of partial income replacement for male and female physicians who have a newborn or newly adopted child. Annual base funding in 2021/22 is $4.3 million.

Physician Disability Insurance Program (PDI)[5]

Provides income replacement to eligible physicians who become disabled. Annual base funding in 2021/22 is $11.7 million.

Physician Health Program (PHP)[6]

Providing advocacy and support services to physicians and their families. The PHP is operated by the Physician Health Society of BC. Annual base funding in 2021/22 is $2.1 million.

In addition to the specified annual base funding for the various benefits plans listed above, $34.59 million[7] is available for 2021/22, and earmarked for the PDI, CME, CPRSP and PLP benefits program as determined by the Benefits Committee.

### KEY FACTS

- The Benefits Subsidiary Agreement of the PMA:
  (a) identifies specific benefits available to physicians;
  (b) describes eligibility criteria for physicians to participate in the benefit plans;

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[1] CMPA - 2019 Physician Master Agreement - Benefits Subsidiary Agreement Articles 6.7 and 6.8 (Extraordinary Amount - Maximum $17M – 2021/22 Requirement: 70% of 10,555,715 which is $7.389M)
[2] CME - 2019 Physician Master Agreement - Benefits Subsidiary Agreement Article 6.1(b)
[3] CPRSP - 2019 Physician Master Agreement - Benefits Subsidiary Agreement Articles 6.1(c) and 6.4
[4] PLP - 2019 Physician Master Agreement - Benefits Subsidiary Agreement Article 6.1(d)
[5] PDI - 2019 Physician Master Agreement - Benefits Subsidiary Agreement Article 6.1(a)
[6] PHP - 2019 Physician Master Agreement – 2019 Benefits Subsidiary Agreement Article 6.11
[7] Additional funding - 2019 Physician Master Agreement – 2019 Benefits Subsidiary Agreement Articles 6.1(e ), 6.2, and 6.3

(c) assigns responsibility for the oversight and administration of the benefit plans to the Benefits Committee; and
(d) identifies Government's annual funding commitment to the benefit plans.

- The Benefits Committee is a joint Government/Doctors of BC committee with up to 6 sitting members, 3 from Government (including 1 representative from the health authorities) and 3 from the Doctors of BC. The committee meets a minimum of twice per year to provide oversight to the administration and application of the benefits plans including: establishing eligibility and entitlement criteria; setting the annual budget; and approving the year-end financial statements for each benefit program.
- The Benefits Administration Agreement signed between the Doctors of BC and government gives responsibility for the day-to-day administration of the benefit plans to the Doctors of BC Benefit Administration Group. The Doctors of BC recovers administration fees from the annual benefit plan funding provided by Government.

## FINANCIAL IMPLICATIONS

- The 2020/21 expenditure for the benefit programs as per the PMA was $190.660 million and included $74,944 in quarantine income replacement[8], a compensation to physicians required by the Provincial Health Officer to undergo a period of quarantine as a result of exposure to a communicable disease while providing medical services.
- The 2021/22 commitment for these benefit programs as per the PMA is $215.074 million.

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**Approved:**
June 1, 2021– Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 3, 2021 – Brenda Rafter, A/Executive Director obo Philip Twyford ADM, Finance and Corporate Services Division

[8] 2019 Physician Master Agreement - Benefits Subsidiary Agreement Article 9.1 – Quarantine Income Replacement

# LEGISLATIVE SESSION - FACT SHEET

## Physician Master Agreement

### TOPIC

The 2019 Physician Master Agreement (PMA) is signed by the government, Doctors of BC, and the Medical Services Commission and covers the period April 1, 2019 – March 31, 2022. The PMA provides the framework for managing the ongoing relationship between the government, health authorities, physicians, and the Doctors of BC. The PMA includes a number of subsidiary agreements and appendices.

### CURRENT SITUATION

- The agreement was ratified by Doctors of BC members on April 12, 2019. Approximately one third of members voted. Only 3% of those participants voted against it.
- The agreement provided for a one-time payment in the first year to physicians meeting the eligibility requirements. This payment was funded through a combination of the funding available for the business cost premium and surplus funding available in the Joint Collaborative Committees. Eligible physicians have each received a payment of approximately $6,900, administered by Doctors of BC.

### KEY FACTS

- The subsidiary agreements provide additional details related to:
  - Programs specific to family physicians (General Practitioner Subsidiary Agreement);
  - Programs specific to specialists (Specialist Subsidiary Agreement);
  - Rural programs (Rural Practice Subsidiary Agreement), which provide financial incentives for physicians to establish practices in rural and remote communities;
  - Alternative payment programs (Alternative Payments Subsidiary Agreement), and outlines the specific terms and conditions of alternative payment agreements; and
  - Benefits (Benefits Subsidiary Agreement).
- Appendices to the PMA contain language related to the Medical On-Call Availability Program and specific adjustments to compensation rates for fee-for-service and alternative payments.
- The PMA provides the following funding allocations (in millions):
  - A 0.5% annual general increase to fees and alternative payment rates ($61.4)
  - Additional funding to support full-service family practice and primary care reform ($56.1 through the General Practitioners Services Committee)
  - Physician benefits enhancements, particularly to the Contributory Professional Retirement Savings Plan starting in the second year ($66)
  - Specialist disparity ($42.7 to be allocated by an adjudicator)
  - Business cost premium to be applied starting in the second year ($35.7)
  - Adjustments to APP rates to address issues of equity ($20 through a joint committee)
  - Increased compensation for after-hours services ($20)
  - Increased funding for rural programs ($8.5)
  - An increased lift of 7% to sessional rates ($7.1)
  - Other increases including additional funding for the Specialist Services Committee, the Shared Care Committee, and new fees for general practitioners and specialists ($13.5).
- The agreement also provides for a transfer of Joint Collaborative Committee fees to the Available Amount, effective April 1, 2020.

### FINANCIAL IMPLICATIONS

The negotiation mandate for the 2019 PMA conforms to the Public Sector Employers' Council Secretariat bargaining mandate for the broader public sector. The agreement provides an incremental $331 million over three years on an annual base of $4.516 billion.

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 12, 2021 – Peter Klotz, A/ACFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Postgraduate Medical Education

### TOPIC

The University of BC's (UBC) postgraduate medical education (PGME) programs are distributed across the Province and continue to expand in alignment with BC's physician workforce requirements.

### CURRENT SITUATION

COVID-19

- The Medical Council of Canada (MCC) continues to closely monitor the COVID-19 situation and potential impacts on future exams. [1] Timelines for certification, assessments and national matches have been impacted. All written and applied exams offered by the Royal College of Physicians and Surgeons of Canada will be delivered online in 2021. [2] The oral exam component of the College of Family Physicians of Canada Certification exam is not required for candidates writing the Certification exam for the first time in 2021.[3] UBC's mandatory Clinical Assessment Program will be delivered virtually in January 2021.[4] Canadian Resident Matching Service (CaRMS) timeline includes a revised April 20, 2021 R-1 match day. [5]
- UBC PGME residents are identified as essential health workers and are eligible for temporary pandemic pay given specified criteria.[6] Residents are also included in the vaccine rollout via the health authorities. [7]
- On March 16, 2020, UBC Faculty of Medicine released a statement supporting the re-deployment of residents across BC to assist programs and health authorities with clinical coverage during COVID-19.[8]

Government Financial Information

Advice/Recommentations

Second Medical School in BC

The Ministry of Health will support the Minister of Advanced Education and Skills Training to launch BC's second medical school. As part of the planning of a second medical school, consideration will be given to both undergraduate and postgraduate medical education.

### KEY FACTS

- UBC administers BC's only provincially distributed medical program in partnership with regional post-secondary institutions, health authorities, communities and other physician practices. The Ministry of Advanced Education, Skills and Training funds undergraduate medical education (UGME) and the Ministry of Health funds PGME.
- UBC 's medical program is contributing to the overall increase in the number of physicians practicing in BC.[9] Overall, 71% of UBC UGME grads and 76% of PGME residents remain in BC to practice; 47% of UBC UGME graduates return to BC after completing PGME out of province; 67% of UBC PGME residents who did UGME

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[1] MCC. (2020). Update on COVID-19. https://mcc.ca/about/covid-19/. Last accessed January 20, 2021.
[2] RCPSC. (2021). 2021 Exams Update. https://newsroom.royalcollege.ca/2021-exams-update-introducing-online-exams-for-all/. Last accessed Jan 20, 2021.
[3] CFPC. (2021). Impact of Covid-19 on Certifications and Exams. https://www.cfpc.ca/en/education-professional-development/examinations-and-certification/certification-examination-in-family-medicine/impact-of-covid-19-on-certification-and-examinati. Last accessed January 20, 2021.
[4] UBC Faculty of Medicine. (2021). Clinical Assessment Program. https://imgbc.med.ubc.ca/clinical-assessment/. Last accessed January 20, 2021.
[5] CaRMS. (*2021) R-1 Main Residency Match, https://www.carms.ca/2021-cycle-updates/#1587995081432-3c08a47d-4be7.* Last accessed Jan 18, 2021.
[6] B.C. COVID-19 Temporary Pandemic Pay - Province of British Columbia (2020), https://www2.gov.bc.ca/gov/content/safety/emergency-preparedness-response-recovery/covid-19-provincial-support/temporary-pandemic-pay. Last accessed January 22, 2021.
[7] UBC. *COVID-19 and UBC PGME*. (2021). https://postgrad.med.ubc.ca/current-trainees/covid-19-how-is-ubc-faculty-of-medicine-monitoring-the-situation/. Last accessed January 22, 2021.
[8] UBC PGME *COVID-19 Guidelines on Resident Redeployment* (2020). https://postgrad.med.ubc.ca/wp-content/uploads/2020/03/UBC-PGME-GUIDELINES-ON-RESIDENT-REDEPLOYMENT-V2-Mar.-17.pdf . Last accessed January 20, 2021.
[9] UBC Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2020). Sankey. Data as of October 2020.

out of province remain in BC to practice; and 91% of UBC UGME graduates who also complete UBC PGME remain in BC to practice

- UBC UGME is a 4-year degree program that results in a Doctor of Medicine (MD) upon graduation. UGME candidates must often apply multiple times to a variety of medical schools nationally before they are admitted. 288 students begin UBC UGME each year at one of the 4 regional distributed University Academic Campuses. [10]

| UGME Program Name | Intake # (students) | University | City |
|---|---|---|---|
| Vancouver-Fraser Medical Program | 192 | University of BC - Vancouver | Vancouver |
| Northern Medical Program | 32 | University of Northern BC | Prince George |
| Island Medical Program | 32 | University of Victoria | Victoria |
| Southern Medical Program | 32 | University of BC - Okanagan | Kelowna |

- UGME graduates must complete PGME as an eligibility requirement for certification that leads to licensure and independent practice. Newly graduated UGME students compete nationally for PGME positions through CaRMS, the matching service for medical education in Canada.
- To align with UBC's 288 UGME graduates each year, at least 288 entry-level PGME residency positions are allocated to CMGs in the first iteration of the CaRMS. In 2020, UBC posted 352 R-1 (entry-level) CaRMS positions: [11] Including 174 positions in Family Medicine and 178 in the Royal College specialties. [12]
- There were 294 CMG and 58 IMG stream positions in the first iteration, including 52 IMG positions in Family Medicine and 6 in selected specialties. Note that CMGs and IMGs compete together for unfilled positions in the second iteration of the CaRMS match.
- To support workforce demand and Ministry strategic priorities, at least 60% of entry-level PGME positions are in Family Medicine and generalist specialties (Internal Medicine, Obstetrics/ Gynecology, Pediatrics, Psychiatry).
- For the July 2020 PGME intake, UBC was the only university in Canada to fill all (100%) of its 174 Family Medicine PGME positions within the first iteration of CaRMS.[13]
- UBC Faculty of Medicine is now the largest single Family Medicine PGME training program in Canada
- Over 1,400 UBC residents provide health care provision as they train across BC, including 65+ Community Education Facilities, 17 Affiliated Regional Centres, 11 Clinical Academic Campuses and 19 regionally distributed Family Medicine training sites. [14] Distribution of PGME enables residents to experience a variety of urban, rural and remote clinical settings, to build critical relationships and connections that, in turn, influence practice location.[15]
- The following table shows PGME resident rotations by health authority:[16]

| PGME Resident Rotations | FHA | IHA | NHA | VCH | VIHA |
|---|---|---|---|---|---|
| Specialist Rotations | 600 | 147 | 66 | 1059 | 264 |
| Generalist rotations | 359 | 116 | 61 | 537 | 176 |
| Family Medicine Rotations | 139 | 109 | 57 | 128 | 110 |

- Government remains committed to its significant annual investment into medical education. It is expected British Columbians will continue to see the increasing benefits of this investment as expanded cohorts of newly trained UBC residents transition into practice within BC's diverse communities across the Province.

## FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**

January 31, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[10] UB. Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2020). UGME – Practice Locations. Data as of October 2020.
[11] CaRMS. (2020). *R1- Data and Reports: Tables 8.* https://www.carms.ca/wp-content/uploads/2020/05/2020_r1_tbl8e.pdf. Last accessed January 21, 2021.
[12] CaRMS. (2020). *R1- Data and Reports: Tables 8.* https://www.carms.ca/wp-content/uploads/2020/05/2020_r1_tbl8e.pdf. Last accessed January 21, 2021.
[13] CaRMS. (2020). *R1- Data and Reports: Table 39.* https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 20, 2021.
[14] UBC Faculty of Medicine. (2021). *Campuses.* UBC. https://www.med.ubc.ca/about/campuses/ Last accessed January 15, 2021.
[15] UBC Faculty of Medicine. (2021). Interactive Map: Provincial View UBC Family Medicine Residency https://carms.familymed.ubc.ca/training-sites/interactive-map/. Last accessed January 15, 2021.
[16] UBC Faculty of Medicine Long-Term Outcomes Evaluation Annual Data Source Workbook. (2020). PGME Clinical Placements. Data as of October 2020.

# LEGISLATIVE SESSION - FACT SHEET

## Practice Ready Assessment-BC for Family Physicians

### TOPIC

- Internationally trained family physicians (FPs), also referred to as International Medical Graduates or 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.

### CURRENT SITUATION

- Due to the COVID-19 pandemic, the PRA-BC program postponed the Spring 2020 intake to Fall 2020 for the following reasons:
  - Changing government guidelines requiring healthcare organizations to adapt service delivery models to focus physician resources on patient care;
  - Concern that physicians and community clinic staff may not have the capacity to administer, conduct and complete the program's 12-week Clinical Field Assessment (CFA);
  - Disruption and uncertainty around candidates' ability to travel and participate in the program.
- PRA-BC implemented a Fall 2020 intake and will be implementing a Spring 2021 intake. PRA-BC is continuing to identify community risks and mitigation strategies to address the evolving pandemic situation.

### KEY FACTS

- There are 4 pathways to practice medicine in BC for internationally trained FPs who are licensed, practicing physicians in other countries:
  1. Retake postgraduate medical education in Canada.
  2. Graduates from an accredited postgraduate family medicine training program in an approved jurisdiction 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) .
  3. Undergo a practice ready assessment in Canada for at least 3 months.
  4. In 2020, the College of Physicians and Surgeons of BC drafted new bylaws to introduce a restricted "associate physician (AP)" class of registration for physicians who are not eligible for a full or provisional license. Once fully established, this pathway will allow physicians with a minimum of two years accredited postgraduate medical training to work under supervision in structured team-based specialty care settings to increase capacity and service delivery (see AP Fact Sheet for details).
- The PRA-BC program supports the 3rd pathway for FPs. The curriculum includes a 2-week centralized orientation in Vancouver before undergoing a 12-week CFA under the supervision of a fully licensed FP in a BC community.
- PRA-BC follows a standardized format approved by the Medical Council of Canada's National Assessment Collaboration. The format meets the medical regulatory authorities' provisional licensure requirements across Canada, aligned with the Agreement on Internal Trade which enables interprovincial labour mobility. The Collaboration consists of representatives from provincial health ministries, faculties of medicine, medical regulatory authorities, and internationally trained physicians from across Canada.
- PRA-BC is funded by the Joint Standing Committee on Rural Issues (JSC), a partnership between the Ministry of Health and Doctors of BC, to help address access to rural FPs in BC by requiring successful applicants to provide a three-year Return of Service (ROS) in a rural 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 a priority given to placements in Primary Care Networks (PCN).
- ROS sites are communities of need, selected semi-annually by health authorities. Starting in 2020, placement opportunities were expanded to include PCN communities.

- As of May 21, 2021, 142 IMGs have successfully completed the PRA-BC Program and have been placed in 49 ROS communities[1] across BC, as follows: Northern Health: 56, Interior Health: 44, Island Health: 30, Vancouver Coastal Health: 8, and Fraser Health: 4 (total 142)[2].

Background

- Until 2012, the College of Physicians and Surgeons of BC 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 2 (i.e., enabling licensure of FPs from the US, Australia, UK and Ireland), and the Collaboration began work on pathway 3: a practice assessment for FPs.
- In 2013, the Collaboration finalized the PRA for foreign-trained FPs. Also, in 2013, the Collaboration began work on a future PRA for foreign-trained general specialists, beginning with general internists and psychiatrists. A pathway for foreign-trained specialists has not yet been established.

## FINANCIAL IMPLICATIONS

In 2019/20, $2.29M was provided to support PRA-BC.[3]

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**Approved:**
February 7, 2021 – Peter Klotz oboPhilip Twyford, ADM, Finance and Corporate Services Division
May 27, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[1] Physician Services Branch; Health Sector Workforce and Beneficiary Services Division,. Fall 2020 PRA-BC Evaluation Report (Data as of May 21, 2021).
[2] Ibid.
[3] Practice Ready Assessment for Family Physicians payments past and future \\mario\msp\Decision Support - MSP\FACT SHEETS\2017-18\PRA\Note 01_HEABC Historical Payments.xlsx

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Coverage Out-of-Country Medical Services

### TOPIC

Provincial coverage may be requested for elective medical treatment services outside Canada when medically necessary health care services are not available in British Columbia or elsewhere in Canada.

### CURRENT SITUATION

- The *Medicare Protection Act* delegates the authority to direct the provincial coverage for elective out-of-country medical treatment services, to the Medical Services Commission (the Commission).
- To detail coverage, application and the review process, the Commission publishes the Out-of-Province and Out-of-Country Medical Care Guidelines (January 19, 2011).
- The Beneficiary and Diagnostic Services Branch reviews applications for provincial coverage for elective medical treatment services outside Canada on behalf of the Commission.

### KEY FACTS

- The appropriate, attending medical specialist in BC may recommend medical treatment and if treatment is not available in Canada, the specialist may request provincial coverage for treatment outside Canada.
- The specialist and/or tertiary medical center in BC application for provincial coverage details when treatment is medically necessary, the appropriate standard of care for the medical condition is not available for a BC resident anywhere in Canada and treatment outside Canada is not experimental or developmental medical treatment.
- If provincial coverage is not approved for out-of-country medical treatment, the Commission provides a review process. The *Medicare Protection Act* does not impose a duty on the Commission to review and decide on requests to review, but, rather, it is the Commission's choice to offer an option for review hearings.
- From April 1, 2019, to March 31, 2020, 146[1] applications were reviewed for elective medical treatment outside Canada, 98 applications were approved, 48 applications were either denied or deferred for additional information.

### FINANCIAL IMPLICATIONS

In 2019/20, approximately $6.5 million[2] (Canadian) was approved for elective out-of-country physician services. Funding for out-of-country physician services is supported by the Out-of-Country Physician Budget.

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**Approved:**

January 25, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 2, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 8, 2021 – Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] Medical Services Plan, Out of Country (CICSPG)
[2] HealthIdeas, MSP Miscellaneous Adjustment Report – FI 06666, 08889, 77002, and 77004

# LEGISLATIVE SESSION - FACT SHEET

# Provincial Health Workforce Planning

## TOPIC

Update on provincial health workforce planning in BC. As specified in the current mandate letter and service plan, the Ministry of Health is developing a comprehensive health human resources strategy (HHR Strategy) to be completed in the current fiscal year.

## CURRENT SITUATION

The Ministry is currently refreshing the last iteration of the HHR Strategy, which will lay out a 5-year action plan and include a clear implementation pathway, accountability framework and performance monitoring approach to ensure that specified objectives are met. The timeline for completion of the plan is Fall 2021.

## KEY FACTS

Mandate and Service Plan Commitment to a Comprehensive HHR Strategy

- The Minister of Health mandate letter, dated November 26, 2020 includes direction to implement a comprehensive HHR Strategy, expanding training in all fields of health care and improving the Province's credential recognition process and licensing. The Ministry has incorporated this item in its current service plan and release is anticipated within fiscal 2021/22.
- The HHR strategy will build on outcomes of a comprehensive, continuous provincial health workforce planning process the Ministry undertakes with health authorities and other partners. Government Financial Government Financial Information

- It is anticipated the HHR Strategy will continue to place a strong emphasis on increasing health workforce supply through health education and targeted measures to facilitate recruitment. This includes the expansion and distribution of health education programs announced in Budget 2021 ($96M over 3 years).
- A primary purpose is to enable government's strategic agenda for the health system with a focus on key service areas: primary care, seniors services, mental health, public health and surgical.
- The development process and its outcomes reflect a Gender-Based Analysis Plus (GBA+) approach, provincial commitments to the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) and recommendations from the *In Plain Sight* report.
- Recognizing the economic and social benefits of investment in health services, strategic actions and objectives will be closely connected to *StrongerBC and BC's Restart Plan.* The HHR Strategy will also include collaboration across government. Key partner ministries include: Advanced Education and Skills Training; Mental Health and Addictions; Jobs, Economic Recovery and Innovation; Municipal Affairs; and Social Development and Poverty Reduction.

Long term Growth in service demand continues to drive health sector employment

- Like other jurisdictions, BC is experiencing decades-long growth in the demand for health services driven by a growing and aging population, higher prevalence of chronic conditions, advances in care, strategic investments to expand access and improve quality, shifting societal expectations and other factors. The result has been an increasingly competitive labour market for health workers provincially, nationally, and globally.
- Health services are labour intensive. BC's publicly funded health sector employs over 216,000 workers at a cost of more than $19 billion, or 51% of total compensation in the provincial public sector.[1]
- Between 2017 and 2020, overall employment in BC's Health Care Sector increased from 250,300 to 265,800 or 6.2% compared to population growth of 4.4%. Consistent with this trend, the sector's share of total provincial employment rose from 9.8% in 2017 to 10.7% in 2020.[2]

[1] Public Sector Employers Council, B.C. Public Sector Compensation Annual Forecast, 2021

[2] BC Stats, British Columbia Employment by Detailed Industry, Annual Averages, January 2021

- BC's Labour Market Outlook projects that health care will continue to see large increases in job openings to 2029 – 117,100 over the 2019 baseline and 13.6% of total provincial job openings; 56% of these will come from the need to replace retiring workers, while the remaining 44% will result from expansion in response to growing service needs. [3]

COVID-19 has amplified pre-existing labour market challenges

- While BC has been successful in increasing its health workforce at a greater rate than population growth, health labour market supply challenges continue to manifest for a wide range of occupations, including registered nurses, family physicians, nurse practitioners, physiotherapists, medical laboratory assistants and technicians, health care assistants and many others.
- Tight health sector labour markets have resulted in a variety of challenges that are now being amplified as BC's health system manages the COVID-19 pandemic. These include greater difficulty in providing optimal staffing levels, more time to fill vacancies, increasing turnover and higher levels of stress and burnout due to increasing workloads.
- Government has taken immediate steps to address these pressures through funding and innovative programming to meet urgent staffing needs. For example: the Health Career Access Program; net new positions to support enhanced long-term care and assisted living visitation and infection prevention and control; and provincial support for contact tracing.
- Workforce challenges are not limited to clinical staff; they are also present in leadership, management, administrative and support positions. Through the economic recovery, a tighter general labour market is likely to be accompanied by the ongoing recruitment and retention difficulties for many of these roles.
- Currently, the Ministry of Health views surplus workforce demand as a primary impediment to timely and effective health service delivery. If left unaddressed, workforce-related constraints are also likely to be a significant barrier to the scaling and strategic repositioning of services required to meet the patient and population health needs of British Columbians now and in the future.
- The effects of labour market imbalances are felt across the province but can vary significantly by geography and service area.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

June 10, 2021 – Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Service Division
June 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[3] BC Labour Market Outlook, 2019

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Occupational Health and Safety Organization

### TOPIC

- A new provincial occupational health and safety (OHS) organization has been created to bring a coordinated and integrated effort to improve the health and safety of heath care workers and ensure meaningful participation from the employer and worker.
- The BC Health Care Occupational Health and Safety Society (OHS Society) will prioritize efforts that will support and enhance employer's health and safety management systems and initiatives. To achieve this, the OHS Society will establish institutional systems, including the sharing of data, information, and experiences across the sector.

### CURRENT SITUATION

- On November 30, 2020, the OHS Society was incorporated as a non-profit society under the *Societies Act*. The OHS Society will be responsible for developing provincial frameworks, systems, and programs aimed at improving workplace health and safety across the BC health care sector.
- The OHS Society is governed by a Board of Directors representative of senior leaders appointed from stakeholder organizations (6 employer representatives, 6 worker representatives, a representative from the Doctors of BC, and an independent Chair). The Ministry of Health and WorkSafe BC will participate as ex-officio members.
- On December 31, 2020 Roberta Ellis was appointed as the non-voting Independent Chair for the Board of Directors.
- The OHS Society's constitution and by-laws are complete and in effect as of December 2020. The Board is currently conducting a search to hire a Chief Executive Officer (CEO), with a hire slated for late Summer/Fall of 2021. The CEO, in consultation with the Board, will determine the staff structure, infrastructure of the organization, and which initiatives will be prioritized for the 2021/22 fiscal year.
- A strategic framework for the OHS Society is currently under development.

### KEY FACTS

- Workplace injuries 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. According to a WorkSafe BC report, there were claims costs exceeded $124 million in 2019, an increase of over $17 million from the previous year.[1] Further, days lost due to violence and non-violence increased by 54,217 between 2018 and 2019.[2]
- The objective of the OHS Society is to develop work products to further the implementation of programs and activities that increase safety in the workplace. As such, the OHS Society will prioritize efforts that will support and enhance employers' health and safety management systems and initiatives. The initiatives of the organization have been identified as:
    - Promote a safe and healthy work environment and organizational safety culture through prevention of injury initiatives, safe workloads, safe work practices and healthy workforces, including pilot and demonstration programs.
    - Prevent and reduce the incidence of injuries (physical and psychological) and occupational diseases.
    - Support the adoption of leading (best) practices, programs, or models, including the implementation of Canadian Standards Association's Occupational Health and Safety Management System and Psychological Health and Safety in the Workplace.
    - Facilitate cooperation between unions, employers, and Doctors of BC on health and safety issues.
    - Facilitate and provide education and training for effective functioning of local Joint Occupational Health and Safety committees.
    - Improve awareness of and compliance with the *Workers Compensation Act*, the Occupational Health and Safety Regulation.

[1] WorkSafe BC Annual Statistical Report, 2019; 2018.
[2] Source: WorkSafe BC Data Request (July 2020).

# LEGISLATIVE SESSION - FACT SHEET

Background

- In the 2019 round of collective bargaining, all parties acknowledged the need for a coordinated and integrated effort to improve the health and safety of health care workers and renew and rebuild a provincial framework/structure for occupational health and safety in the BC health care sector
- All 2019 agreements with the individual bargaining associations, and the Doctors of BC, contained provisions for funding which may be allocated, in whole or in part, to the OHS Society for projects or other work. All bargaining associations, and the Doctors of BC, may choose to use all or part of the specific funding, in conjunction with the member employers and HEABC, to identify and address initiatives specific to the bargaining association or the Doctors of BC.
    - Ambulance Paramedics and Ambulance Dispatchers Association: $100,000/year[3]
    - Communities Bargaining Association: $250,000/year[4]
    - Facilities Bargaining Association: $500,000/year[5]
    - Health Sciences Professional Bargaining Association: $250,000/year[6]
    - Nurses Bargaining Association: $1,290,000/year from Enhanced Disability Management Program Cost Savings[7]
    - Resident Doctors of BC: $30,000/year[8]
    - Doctors of BC: $500,000/year[9]
- Prior to the 2019 round of bargaining, several collective agreements contained provisions for occupational health and safety related funds. The parties to those agreements retain their control over these funds and may contribute these funds to support work that the OHS Society will undertake, or may continue with, new or existing projects and processes. The parties, in collaboration with the OHS Society, will determine mechanisms for committing those funds. These funds are separate from the funding provided by the Ministry to the OHS Society.
- Historically, the health sector has experienced an array of health and safety initiatives at the provincial level through a combination of collective agreement provisions, government directives, employer programs and WorkSafeBC initiatives.
- Associated with the initiatives, the BC Occupational Health and Safety Agency for Healthcare (OHSAH) was in place from 1998-2010 and worked with all members of the healthcare community to develop guidelines and programs designed to promote better health and safety practices and safe early return-to-work; to promote pilot programs and facilitating the sharing of best practices; and, to develop new measures to assess the effectiveness of programs and innovations in this area.
- OHSAH closed in 2010 for several reasons, including budgetary pressures and a heavy focus on academic research. Since then, there has been no provincial and/or independent body that has taken the lead in occupational health and safety in the health sector.

## FINANCIAL IMPLICATIONS

The Ministry has committed to providing $8.5 million over 3 years (2019/20-2021/22) to support the establishment of the BC Health Care Occupational Health and Safety Society[10].

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**Approved:**

February 28, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 1, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

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[3] Collective Agreement between The Ambulance Paramedics and Ambulance Dispatchers Bargaining Association and HEABC, Appendix 11 - Memorandum of Agreement, pp. 99-100
[4] 2019-2022 Health Services and Support – Community Subsector Association Collective Agreement: Summary of Changes. p.49.
[5] 2019-2022 Health Services & Support Facilities Subsector Collective Agreement: Summary of Changes.
[6] 2019-2022 Health Science Professionals Bargaining Association Provincial Agreement: Summary of Changes. pp. 84-85.
[7] 2019-2020 Provincial Collective Agreement between HEABC and Nurses' Bargaining Association, Appendix A.3 Memorandum of Agreement: NBA Occupational Health and Safety and Violence Prevention Initiatives. pp. 191-192.
[8] Collective Agreement between HEABC and RDBC. Memorandum of Agreement between HEABC and Resident Doctors of British Columbia. pp. 47-48.
[9] Physician Master Agreement - Memorandum of Agreement Physical/Psychological Safety. Section 9: Project Funding. pp. 5-6
[10] News Release: Reducing injuries for health-care workers focus of new safety organization

# LEGISLATIVE SESSION - FACT SHEET

# Psychological Health and Safety in the Health Care Workplace

## TOPIC

The Ministry of Health has directed health authorities to adopt the Canadian Standards Association (CSA) Group's National Standard for Psychological Health and Safety in the Workplace (the Standard).[1]

## CURRENT SITUATION

- The Ministry, in partnership with the Health Employers Association of BC (HEABC), health authorities (including Providence Health and the First Nations Health Authority), unions, professional associations, and other stakeholders (e.g., Canadian Mental Health Association) established the Psychological Health and Safety Steering Committee in November 2016.
- The role of the Psychological Health and Safety Steering Committee (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.
- A Measurement Working Group, reporting to PHS SC, was formed to identify and recommend metrics to evaluate progress and outcome of the Standard's implementation. The Measurement Working Group is finalizing a systems-level template that will be used for planning and reporting purposes.
- The health authorities are at various stages of implementation of the Standard.
- In order to support the implementation of the Standard, the Ministry is working with the health authorities, unions and bargaining associations through the Survey Leads Working Group (a sub-committee of the Measurement Working Group) to roll-out a province wide psychological health and safety survey in Fall 2021.
- The *Implementation of the National Standard on Psychological Health and Safety in the Workplace* policy directive (2017) prescribes a policy review and refresh (as needed) in July 2020. Due to the COVID-19 pandemic, the consultation process for the policy review and refresh has been postponed and is expected to take place in Fall 2021.

## KEY FACTS

National Standard – Psychological Health and Safety

- The Ministry's *Provincial Strategy for Health Human Resources* (2015) requires health authorities to adopt the Standard to support the psychological well-being of health care workers and create engaged, healthy, and well-led workplaces. The Standard sets out a framework to actively transform organizational cultures to prevent harm, and promote workers' psychological health and well-being.
- Workplaces with a positive approach to psychological health and safety are better able to recruit, retain and engage workers. Moreover, engaged and healthy workforces are associated with improved care quality, safety and patient outcomes.
- The organization's commitment to psychological health and safety associates with reduced grievances, turnover, injury rates, disability claims, absenteeism, and morale problems.
- The process of implementing the Standard can enhance psychological health and safety by increasing the workers' sense of belonging, building positive relationships, and securing commitment to the system.
- Successful and sustainable implementation of the Standard requires worker involvement in the development, planning, and implementation stages. Organizations are expected to consider 13 psychosocial factors: workplace culture, leadership, respect, psychosocial support, psychological demands, workload, engagement, recognition, work/life balance, physical safety protection, psychological protection, and worker's growth and development.

[1] Canadian Standards Association, Bureau de Normalisation du Quebec. Psychological health and safety in the workplace - Prevention, promotion, and guidance to staged implementation. (CAN/CSA-Z1003-13/BNQ 9700-803/2013). National Standard of Canada. Available as a free download from: https://www.csagroup.org/store/product/CAN%25100CSA-Z1003-13%25100BNQ%209700-803%251002013/

- The recently established BC Health Care Occupational Health & Safety Society (refer to fact sheet) will help advance the implementation of the Standard; however, its role and scope of responsibility have yet to be determined.
- The Ministry's commitment to the Standard was a key component of the 2016 collective agreement with the Nurses' Bargaining Association (NBA). The Ministry reviews progress with the NBA on a quarterly basis and health authorities are also to provide reports to NBA when requested.

Mental Disorder Claims[2]

- As per s 135 (1) of the *Workers Compensation Act*, WorkSafe BC may accept a mental disorder claim of a disorder that resulted from one or more traumatic work-related events or stressors arising out of or during the course of employment.
- Individuals from eligible occupations who are diagnosed with a mental illness, such as post-traumatic stress disorder, do not have to prove their condition resulted from their employment. This fast-tracks the claims process to access supports and compensation once a formal diagnosis has been made.
- The *Mental Health Disorder Presumption Regulation* outlines eligible occupations, including but not limited to: emergency medical assistants (e.g. paramedics), emergency dispatchers[3], 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.[4]
- Mental disorder claims reported to WorkSafe BC for the Health Care & Social Services subsector increased 42.6%, from 1,387 to 1,978 claims, between 2018 and 2020. These include claims where the psychological injury is the primary injury on the claim and where the psychological injury develops as a consequence of a physical injury.
- Paramedical occupations and nurses have seen the highest increase in claims submitted between 2018 and 2020 (paramedical 193 to 290, 50.3% increase; nurses 394 to 576, 46.2% increase).

**Mental Disorder Claims Reported to WorkSafeBC**

| Industry Subsector/classification units | 2018 | 2019 | 2020 | % change 2018 to 2020 |
|---|---|---|---|---|
| All Sectors | 4,404 | 5,440 | 5,402 | 22.7% |
| Health Care & Social Services Sector | 1387 | 1,856 | 1,978 | 42.6% |
| Acute Care | 436 | 584 | 601 | 37.8% |
| Pre-hospital Emergency Health Care | 213 | 293 | 333 | 56.3 % |
| Long Term Care | 236 | 253 | 275 | 16.5% |
| Community Health Support | 166 | 221 | 256 | 54.2% |
| Residential Social Services | 137 | 194 | 218 | 59.1% |
| Counselling or Social Services (not elsewhere specified) | 111 | 188 | 158 | 42.3% |
| Other | 88 | 123 | 137 | 55.7% |

## FINANCIAL IMPLICATIONS

N/A

**Approved:**
June 1, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[2] Mental Disorder Claims, WorkSafe BC, https://www.worksafebc.com/en/resources/about-us/news-and-events/backgrounders/mental-disorder-ptsd-claims?lang=en; Accessed May 25, 2021
[3] Whose duties include the dispatch of firefighters, police officers and ambulance services, as well as those who receive emergency (911) calls from the public.
[4] The presumptive clause for the listed occupations came into effect on April 16, 2019.

# LEGISLATIVE SESSION - FACT SHEET

# Red Cross Support in Long-Term Care

## TOPIC

- On February 1, 2021, the Ministry of Health announced they had partnered with the Canadian Red Cross (CRC) to provide non-clinical, administrative and leadership support for up to five long-term care homes and assisted-living facilities in the Fraser Health and Vancouver Coastal regions that were facing significant challenges due to COVID-19.
- In addition, on March 24, 2021, the Ministry announced the CRC would be one of the community partners supporting the COVID-19 mass immunization clinics across the province. Immunization support provided from the CRC and other partners is non-clinical in nature and assists with administrative and site support such as wayfinding, registration and logistics.
- The CRC is a not-for-profit organization and receives funding from BC on a cost-recovery basis, depending on actual resources expended. The duration of the contract is temporary and depends on the continuing impacts of the pandemic.

## CURRENT SITUATION

- The Ministry signed an agreement with the CRC in late January 2021 to provide temporary staffing support within select long-term care facilities dealing with COVID-19 outbreaks.
- Shortly after the agreement was finalized between the CRC and the Province to bring support to long-term care, BC saw a swift and significant decline in the number of outbreaks in long-term care and assisted living facilities. As a result, the CRC teams were deployed to support the roll-out of the COVID-19 immunization program. The CRC remains on stand-by to support long-term care staffing if required.
- Support from the CRC within long-term care had been intended to include tasks such as meal delivery, light cleaning, and arranging and facilitating virtual meetings with family members.
- The contract has been amended to support staffing in mass immunization clinics in 3 health authorities: Island Health, Interior Health and Northern Health. The CRC is now providing non-clinical support to vaccination clinics in these health authorities. In addition, the contract also allows for the CRC to provide cultural safety services at First Nations communities (Island Health only).
- As of May 14th the CRC is currently present at 13 community sites in BC for COVID-19 vaccination administration and support. To date, the CRC has supported 17 sites across the province (4 sites have now been demobilized). CRC is transitioning to locally hired site managers and emergency care workers and is working to fill gaps in the available workforce by increasing recruitment. Total staff deployed/hired by CRC to date is 258 (note that these may include duplicates in some instances for individuals who have worked at multiple sites).
- The number of total sites either complete, active or in planning by health authority are:
    - Interior Health: 13 sites (including 2 which have now been demobilized and 1 planned for the future)
    - Island Health: 8 sites (including 2 which have now been demobilized and 2 planned for the future)
    - Northern Health: 1 site
- Individuals being hired locally to fill these roles include those who have been hardest hit by the pandemic, such as tourism, retail and hospitality workers.
- The CRC has provided similar supports to long-term care (LTC)/assisted living (AL) facilities and is supporting immunization efforts in other provinces through contracts with the federal government.

## KEY FACTS

- CRC's mandate for providing vaccination support includes non-clinical support to community sites (all in non-CRC facilities) through paid personnel. CRC roles include greeter, data entry, flow monitor, generalist/runner, and CRC site manager for a period of up to 6 months. When the response was initially stood up, CRC staff from across the country were brought into BC to support the immediate needs, with the intention of hiring local staff to replace these individuals as able. These CRC staff had the ability to support either LTC response or immunization clinics.

- The Ministry engaged the CRC in December 2020, during the height of the second wave of the pandemic, to build emergency response teams consisting of non-clinical and administrative staff to be deployed at select LTC/AL sites on a priority basis. Support was to involve the immediate deployment of any existing CRC resources with capacity and relevant experience to the highest priority sites, as well as hiring and deployment of additional resources by the CRC.
- Emergency teams were to be assembled to address immediate and urgent needs. These teams are assembled and deployed based on need of impacted facility. Teams may include site managers, health and safety advisors, and support aides (SA).
- Initial assessment of the first 3 Fraser Health sites happened on January 29 (Royal City Manor, New Westminster), February 1 (Evergreen Baptist, Surrey), and February 8, 2021 (George Derby Centre, Burnaby).
- However, prior to actual deployment of staff, these sites were removed from active outbreak status, and no deployments took place.
- Typical deployment at an LTC site includes a team of about 20 individuals (2 teams of 10 to cover 7 day a week services), for a maximum of 4 weeks per site.
- SAs would have been deployed to support facilities and residents with the basic activities of daily living, and provide the following services: Socialization & Engagement; Nutrition Support; Organization & Light Cleaning; Safety & Well-being; and Reporting and Documentation

Background

- The CRC has been engaged by the federal government since mid-2020 to begin preparations to provide surge support to provinces as and when needed. Accordingly, the CRC has been recruiting across the country for a number of months to ensure they are able to deploy when and where needed.
- However, the agreement between BC and CRC is a bilateral agreement, which is not connected with the federal contract.
- The CRC's scope includes leadership and administrative support, including infection prevention support.
- In addition, they will be recruiting locally for support aide positions, who are generalists who are given rapid Red Cross training to work in these types of environments. All staff will undergo criminal record checks.
- The CRC trains their personnel to a high standard both in terms of quality of care in support of clients, as well as rigorous infection prevention and control procedures in compliance with federal and BC best practices and regulations.
- The initial contract had been for up to 5 LTC sites, and ran until April 30, 2021. The contract amendment supporting immunizations was signed on March 25, 2021 and the term of the agreement was extended to September 30, 2021, with further extension available if needed.

## FINANCIAL IMPLICATIONS

- As of May 4, 2021, CRC has invoiced $110,726 to cover planning, administrative, travel and accommodation costs.
- In addition, as part of the March 25th amendment, the Province agreed to advance the CRC a lump sum of $6M for anticipated services under the agreement.
- Initial contract (SCA) is for maximum $2.9M on cost-recovery basis; the amended contract increased that total to $20.5M.

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**Approved:**
May 21, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Registered Nurse (RN)/Registered Psychiatric Nurse (RPN) Prescribing

## TOPIC

Enabling RN/RPN prescribing to address access barriers to opioid agonist therapy (OAT) and mitigate the risk of mortality for British Columbians during the opioid overdose emergency in BC

## CURRENT SITUATION

- Currently, RNs may prescribe, compound, dispense or administer a limited number of medications.[1]
- As of July 14, 2020, Health Canada has granted a Controlled Drugs and Substances section 56 exemption to specific to buprenorphine/ naloxone (Suboxone®) prescribing by RNs/RPNs in BC. An Order of the Provincial Health Officer (PHO) to permit RNs/RPNs prescribing of buprenorphine/naloxone as aligned with this exemption has been enacted.
- In addition to the public health order, the Ministry of Mental Health and Addictions (MMHA) and the Ministry of Health (MoH) are working with the Office of the PHO to develop an updated policy directive for prescribers and health authorities. This builds on the existing risk mitigation clinical guidance released in March 2020 in partnership with the BC Centre on Substance Use (BCCSU). The policy directive will support careful expansion of safer pharmaceutical alternatives that can be prescribed and dispensed by doctors, pharmacists and nurses beginning with Suboxone® prescribing for nurses. The BC College of Nurses and Midwives (BCCNM) have developed draft broad prescribing standards, limits and conditions, along with limits and conditions to facilitate Suboxone® prescribing by RNs/ RPNs for BCCNM Board approval on September 24, 2020.[2] This will come into effect on October 24, 2020 after a 30 day public posting period to ensure sufficient time for due diligence and quality assurance. This will not preclude nurses from beginning the requisite education needed to prescribe Suboxone®. [3]
- After engagement with provincial addictions operational leads, it has been identified that RN/RPN prescription of other OAT agents (i.e. methadone and slow-release oral morphine aka Kadian) be prioritized under this PHO. BCCNM is expected to endorse changes to standards, limits and conditions late January 2021 to add methadone and Kadian as treatments by RNs/RPNs for opioid use disorder. Consultation with stakeholders and development of clinical guidance and education is underway – expected implementation Spring 2021.

### Governance / Committees

Steering Committee - led by MoH and MMHA has been established to address the requirements to enable this restricted activity for RNs/ RPNs in BC Work underway includes:

- General oversight of this initiative, including establishment of BCCNM prescribing limits and conditions and quality assurance processes; and addressing health care system requirements e.g., prescriber numbers and PharmaNet access for RNs/ RPNs;
- Developing the approach to performance monitoring/ evaluation.

Implementation Committee – led by MoH and MMHA, reports to Steering Committee. Composed of diverse representation of all reg HA ops leads, BCCNM, BCCSU, BCCDC.

- Determining the education model to support RNs/RPNs to perform this restricted activity;
- Determining the settings this activity can be performed in, e.g., in the context of nurse-led OAT programs coordinated through recruitment of OAT Nurse Coordinators within health service delivery areas across the province and primary care networks (PCNs) and the specialized community service programs (SCSP);

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[1] BC College of Nurses and Midwives. Scope of Practice for Registered Nurses: Standards, Limits, Conditions, Medications. Retrieved from: https://www.bccnp.ca/Standards/RN_NP/RNScopePractice/part4/section7/Pages/medications.aspx

[2] BC College of Nurses and Midwives. Elizabeth Elliot, Deputy Registrar, Policy, Research & Quality Assurance. September 9, 2020. Personal communications.

[3] [3] BC College of Nurses and Midwives. Elizabeth Elliot, Deputy Registrar, Policy, Research & Quality Assurance. September 17, 2020. Personal communications.

Education Committee – led by BCCSU and composed of addiction clinical experts, operational stakeholders and BCCNM

- Determining the education model to support RNs/RPNs to perform this restricted activity;
- Developing an education program, decision support tools, preceptorship, and clinical practice guidelines leveraging the existing OAT training program developed by BCCSU; and
- Developing the approach to performance monitoring/ evaluation.

Clinical Reference Group – led by MoH, MMHA, BCCNM and BCCSU
Tasked with consulting with clinical addiction experts (i.e. GPs, NPs and RNs), regulatory colleges (including Colleges of Physicians and Surgeons of BC and Pharmacists of BC) to inform work done by Education Committee for DSTs, RN/RPN clinical decisions and referral points.

## KEY FACTS

- OAT provides a stable accessible pharmaceutical alternative to illegal opioids e.g., heroin, fentanyl and its analogues, helping to support individuals who must remain in isolation either because of suspected or confirmed cases of COVID-19 or immunocompromised individuals who must remain in isolation to avoid contracting COVID-19.
- Rural and remote areas of the province consistently report ongoing challenges related to OAT prescriber availability and accessibility. For example, Northern Health recently identified challenges related to OAT service provisions in Fort St. James and First Nations Health Authority has reported that rural and remote communities have limited access to OAT services.
- Providing people with low barrier and accessible OAT has the potential to save lives in the context of dual public health emergencies, particularly in communities without or limited access to prescribers.
- Increasing the scope of practice for RNs/RPNs to include Suboxone® prescribing (and other OAT agents, and safer supply alternatives) will help to address the ongoing barriers to accessing OAT. Ministry partners such as the BCCNM, MMHA and the BCCSU are supportive of actioning this approach.
- Health authorities have established workarounds to allow RN/ RPN access to PharmaNet with a plan to enable access by April 2022.
- It is anticipated that up to 100 nurses will be trained in the first year of the education program (early adopters to be trained by Jan/Feb 2021)); sufficient to deliver the safer supply program in a small number of communities and settings with scale up to additional communities/ settings in future years.[4]

## FINANCIAL IMPLICATIONS

- This initiative falls under the Ministry's 3-year agreement with BCCSU to provide clinical management for substance use disorders.
- A financial analysis is being conducted to determine drug costing estimates in collaboration with the Pharmaceutical, Laboratory and Blood Services Division (PLBSD).

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**Approved:**
January 31, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 7, 2021– Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[4] BC Centre for Substance Use. August 27, 2020. Nurse Prescribing Narrative and Budget.

# LEGISLATIVE SESSION - FACT SHEET

## Regulation of Counselling Therapists

### TOPIC

Since the 1990's, counselling therapist organizations have sought regulation under the *Health Professions Act* (HPA). Modernization of the regulatory framework may impact how groups are designated for regulation under the HPA (see Fact Sheet 'Health Profession Modernization' for more details).

### CURRENT SITUATION

- On August 27, 2020, the Steering Committee on Modernization of Health Professional Regulation released its final report, *Recommendations to modernize the provincial health profession regulatory framework.*[1]
- The Steering Committee's final recommendations for modernizing the regulatory framework for health professions includes the creation of an oversight body to make recommendations on health occupations to be regulated under the HPA. As well as, prioritizing the review of counselling therapists, social workers and emergency medical assistants for consideration of regulation under the HPA.
- The authority to modernize the regulatory framework rests with cabinet and the Legislative Assembly.
- Those requesting regulation are being advised to hold those requests until such time as the modernization work is complete.

### KEY FACTS

- The Federation of Associations for Counselling Therapists in BC (FACT BC) has a long history of advocating for the regulation of counselling therapists.
- In the 1990's, a comprehensive review of health professional regulation in BC was undertaken by the former Health Professions Council (HPC) to make recommendations as to which health professions should be regulated.
- In 1997, the HPC recommended against self-regulation of counselling therapists and recommended alternatives be considered due to: the relatively small number of practitioners; diversity of education, training, and services provided; and, doubts over how effective leadership would emerge from member organizations.
- In 1998, a Ministry-sponsored consultant's report was released which evaluated various regulatory options for counselling therapists. The report did not identify a more suitable option than regulation under the HPA.
- The 'Task Group on Counsellor Certification' has been working under the leadership of the BC Association of Clinical Counsellors (BCACC) to develop a viable model for regulation under the HPA as their preferred option. The Task Group encountered a number of challenges over the years. For example, the Task Group split and reunited in 2012 when the master's degree entry-to-practice requirement was dropped in favour of a competency-based approach. In March 2014, the Task Group became FACT BC.
- FACT BC has 14 member organizations that collectively represent 6,000 counsellors and therapists practicing in BC.[2]
- It is FACT BC's position that 'title-protection' would assist the public to more readily determine who is a regulated health care professional. Unregulated counselling therapists would continue to provide similar services as regulated counselling therapists; however, they would not be permitted to use the title reserved exclusively for the regulated counselling therapists.
- Some of the current member organizations within FACT BC perform a quasi-regulatory function and have processes in place to protect the public. All of FACT BC's member associations provide member accountability to a code of ethics and a standard of practice. For example, the BCACC represents over 4,100[3] Registered Clinical Counsellors (RCC) across BC and requires members to undergo a criminal record check prior to designation as an RCC. Designation also requires a master's degree and supervised clinical training. The BCACC has processes in place to investigate complaints against members.

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[1] https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/recommendations-to-modernize-regulatory-framework.pdf
[2] http://www.factbc.org/ Who we are. Accessed online September 10, 2020.
[3] https://bc-counsellors.org/about-us/about-bcacc/ About BCACC. Accessed online September 10, 2020.

- This correspondence did not include signatures representing social work or clinical counselling Ministry staff met with FACT BC on December 20, 2019 to discuss modernization of BC's regulatory framework proposals as presented in the Steering Committee's consultation paper.
- FACT BC subsequently provided a submission, as part of the public consultation, which advocated for regulation of counselling therapists. While the submission supported a reduction in the number of regulatory colleges, it suggested that like-professions should be grouped together in several multi-profession regulatory colleges. For example, social workers, counselling therapists, and psychologists could be regulated by the same regulatory college.
- On January 7, 2020, FACT BC wrote to the Minister of Health noting their intention to make a formal application for designation under the HPA and seeking advice on the information required to support their application for statutory regulation.
- On December 7, 2020, FACT BC wrote to Deputy Minister Stephen Brown submitting their application for designation under the HPA and a cheque in the amount of $2000 representing the application fee.
- On January 19, 2021, the College of Psychologists of BC wrote to the Minister of Health proposing that the psychologists, social workers and clinical counsellors be amalgamated and form their own umbrella regulatory college. This correspondence did not include signatures representing social work or counselling .
- No province currently regulates all the types of counsellors or therapists represented by FACT BC.
- To date the Minister has not committed to the regulation of counselling therapists.
- Those requesting regulation are being advised to hold those requests until the modernization work is complete
- Significant analysis will be required to determine whether regulation is appropriate for any, some, or all of the types of counsellors or therapists represented by FACT BC.

## FINANCIAL IMPLICATIONS

Counsellors are not funded under BC's Medical Services Plan or Supplementary Benefits.

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**Approved:**
February 11, 2021 - Mark Armitage, Health Sector Workforce and Beneficiary Services

# LEGISLATIVE SESSION - FACT SHEET

## Regulation of Diagnostic and Therapeutic Health Professions

### TOPIC

The professional associations for several diagnostic and therapeutic health (D&T) professions have been advocating for regulation since the mid 1980s. The Ministry of Health has received direction to regulate clinical perfusionists, medical laboratory technologists (MLTs), radiation therapists, and respiratory therapists as health professions under the *Health Professions Act* (HPA). A recent recommendation of the steering committee on modernization of health professional regulation has proposed that these D&T professions be regulated under a newly created multi-health profession regulator tentatively called the College of Allied Health and Care Professionals.

### CURRENT SITUATION

- The steering committee on modernization of health professional regulation released its final recommendations report on August 27, 2020.
- One of the recommendations was to reduce the number of regulatory colleges from 20 to 6.
- This would include two multi-health profession regulators. Tentative names for the two multi-health profession regulators are the Regulatory College of Allied Health and Care Professionals, and the Regulatory College of Complementary and Alternative Health and Care Professionals.
- The regulation of diagnostic and therapeutic professions (clinical perfusionists, respiratory therapists, radiation therapists and MLTs) are recommended by the steering committee to be included within the Regulatory College of Allied Health and Care Professionals. This is alongside dietitians, occupational therapists, opticians, optometrists, physical therapists, psychologists, speech and hearing professionals.
- While this is a final recommendation of the steering committee, the final approval for the regulatory changes needed to bring these amalgamations into effect is subject to cabinet approval.

### KEY FACTS

- Between 1999 and 2002, the former Health Professions Council recommended MLTs, medical lab assistants(MLAs), medical radiation technologists (MRTs), ultra-sonographers, cardiology technologists (CTs), and respiratory therapists (RTs) be designated as health professions under the HPA. The Council recommended against designating clinical perfusionists due to their very small number.
- In 2003, the Ministry pursued the establishment of an 'umbrella' college under the HPA to include all 6 occupations. In March 2004, the 6 professional associations unanimously rejected the concept, citing its complexity and detrimental effect on their professional identities.
- In 2010, the associations communicated their willingness to reconsider an umbrella college.
- In 2011, associations representing MLTS, MLAs, and MRTs started an advocacy campaign, which has submitted more than 500 letters to the Ministry supporting a college.
- In 2012, five associations (representing MLTs, MRTs, CTs, RTs and ultrasonographers) came together as the 'Coalition for a College of Diagnostic and Therapeutic Health Professionals' and renewed their advocacy for an 'umbrella' college. Coalition representatives met with two previous Ministers of Health in 2013.
- In 2014, the Ministry received direction to proceed with establishing a regulatory framework for an umbrella college.
- In early 2015, a working group of Coalition representatives was formed to act as subject matter experts to the Ministry and to advise the Ministry on matters relating to the professional practice of the health professions.
- June 2015 - January 2016 – the Ministry reviewed the recommendations of the Coalition working group and conducted stakeholder consultations with the BC Health Regulators, the Chief Nursing Officers Council, the Health Employers Association of BC, and 'front line' staff to get a better understanding of their day-to-day activities and experiences with supervisors and employers.
- December 9, 2016 – the Ministry published a news release proposing to establish a new college for diagnostic and therapeutic health professions. The Ministry announced the new college would oversee the following four health professions: respiratory therapists, radiation therapists, clinical perfusionists and MLTs.

- The news release noted that once the new college has been substantially implemented, the Ministry would further examine the remaining seven diagnostic and therapeutic occupations to determine if regulation by a college is appropriate, or if an alternative oversight solution (e.g. registry) would be sufficient to ensure public safety.
- As required by the HPA, the proposed regulation designating the four health professions was posted for public feedback until March 9, 2017. The regulatory amendments designating the four professions came into force on April 3, 2017.

Cabinet Confidences; Advice/Recommentations

- Ministry staff have met with Coalition working group members to gather information about their professional practice.

Cabinet Confidences; Advice/Recommentations

- 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). The Cayton Report recommends the Ministry "place a moratorium on creating any new colleges and … consult on how any occupations [now] under consideration for regulation could be registered with an existing College."1 (see fact sheet: Cayton Report – Modernizing the Health Profession Regulatory Framework (Part 2)).
- In 2019, the Minister established a steering committee to consider options and draft a proposal on how to modernize the regulatory framework for health professions in BC. The proposal was released for public consultation between November 27, 2019 and January 10, 2020. Included was a proposal that the four health professions be regulated through either the proposed multi-profession regulator, the College of Health and Care Professions, or one of the other proposed existing colleges.

Cabinet Confidences

- Any changes related to the regulation of diagnostic and therapeutic professions would need Cabinet approval.

## FINANCIAL IMPLICATIONS

No financial commitments have been made with respect to government funding for the amalgamation process.

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**Approved:**
February 11, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[1] https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/cayton-report-college-of-dental-surgeons-2018.pdf p.76

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Withheld pursuant to/removed as

Cabinet Confidences ; Advice/Recommentations ; Government Financial Information

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Withheld pursuant to/removed as

Cabinet Confidences ; Advice/Recommentations ; Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

## Requests for Expanded Scope of Practice

### TOPIC

The Ministry of Health receives frequent requests to expand Scope of Practice (SOP) for various regulated health professionals under the *Health Professions Act* (HPA).[1] These requests usually originate from professional associations, health authorities and interest groups, and may not align with the Ministry's priorities.

### CURRENT SITUATION

- The Ministry regularly receives requests from professional associations, health authorities, regulatory colleges, individual practitioners, and interest groups to expand SOP. While advocating for broadening of SOP is within the role of a professional association, practitioner, or interest group, this advocacy is outside the mandate of the regulatory colleges under the HPA.
- Many requests to expand SOP received by the Ministry do not align with the Ministry's strategic direction or identified service delivery priorities. The requests are often related to professional 'self interest,' as seeking a broadened SOP may expand the service delivery opportunities of an individual health practitioner and in some instances, may be linked to increased health professional compensation/renumeration. The requests are often 'health profession-centric' and have not broadly considered the impact on other regulated health professionals and/or unregulated health occupations, impacts on existing service delivery and funding models, and patient experiences of care.
- The Ministry has received recent requests to expand SOP for the following regulated health professions: chiropractors, dental hygienists, dental technicians, denturists, dietitians, massage therapists, midwives, naturopaths, licensed practical nurses, registered nurses, registered psychiatric nurses, occupational therapists, pharmacists, physiotherapists, podiatric surgeons, traditional Chinese medicine practitioners and emergency medical assistants.

### KEY FACTS

- SOP describes the services a regulated health professional is educated, trained, competent and authorized to provide.
- In BC, health professionals are regulated under the HPA, and their SOP is outlined in their profession specific regulation under the HPA. A health profession's SOP includes a SOP statement and any restricted activities (RAs) they are authorized to provide in BC. For more detailed information on SOP statements and RAs see fact sheet: Shared Scope of Practice – Restricted Activities Regulatory Model.
- As health care service delivery is provincially regulated, there may be variances in how SOP is defined for regulated health professionals across Canada.
- The health professions' regulatory college is responsible for ensuring their registrants are educated, trained and competent to perform the services authorized in the SOP.
- The Ministry receives strategic direction from the Minister's Mandate Letter[2] together with the Ministry's strategic plans and policy papers.
- The Ministry is responsible for directly managing a number of provincial programs and services, most notably Medical Services Plan (MSP) and PharmaCare, as well as responsible for all or part of 37 provincial statutes and associated regulations related to health care services in BC. One of these is the HPA.[3]
- The Ministry is committed to ensuring health care professionals are able to work to their full SOP and to optimizing their existing scopes of practice to ensure multidisciplinary teams are efficient and are making effective use of their resources. Government's new primary health care strategy commits to building on the best practices and solutions that already exist within the health care system but have yet to be fully leveraged throughout the province.

[1] http://www.bclaws.ca/civix/document/id/lc/statreg/96183_01
[2] https://news.gov.bc.ca/files/HLTH-Dix-mandate.pdf
[3] https://www.bclaws.gov.bc.ca/civix/document/id/amr/amr/658625517

Ministry approach to evaluating expanded SOP requests

- The Ministry utilizes the right touch regulation principles when evaluating expanded SOP requests for health professions. This includes identifying the problem before the solution (i.e. 'what is the problem that we are trying to solve?'). As well as, considering the use of non-regulatory solutions before contemplating any regulatory changes, such as expanding the legislated SOP for a regulated health professional.
- When analysing SOP requests, the Ministry has moved away from a siloed profession-centric approach towards a holistic multidisciplinary approach. This involves analysing the overlapping scopes of practice of all health professions who provide related services and the impact on multidisciplinary team function and its subsequent delivery of health care services in BC.
- A significant amount of policy work is required to support any possible SOP expansion, and includes:
    - Alignment with Ministry strategic direction;
    - Assessment against other Ministry regulatory priorities (e.g. opioid crisis, COVID-19, regulatory modernization);
    - Cross-jurisdictional scans of present issues and labour mobility;
    - Assessment of the education and training of health professionals;
    - Assessment of the regulatory college readiness to regulate;
    - Extensive consultation with stakeholders, including the public and other health regulators;
    - Assessment of what other regulated health professions can already do;
    - Assessment of any quality assurance mechanisms that would have to be put into place to ensure certain practices are appropriate;
    - Assessment of the financial implications to the patient and government, and
    - Identification of any operational barriers which may prevent a practitioner working to their full SOP.
- If health care system delivery issues are identified as the primary reason for expanding a SOP, a thorough analysis of operational barriers is undertaken, as there are often existing operational barriers that prevent regulated health professionals from working to their full SOP. There are 3 main types of operational barriers:
    - Legislative - other legislation/regulations that require amendments (e.g. *Vital Statistics Act, Laboratory Services Act*, etc.);
    - System – IT/software/hardware updates (e.g. PharmaNet, MSP billing); and
    - Administrative – process documents/forms development and/or updates (e.g. Health Insurance BC forms, health authority process documentation).
- The Ministry has many competing priorities and any request for changes in SOP are considered in relation to these priorities.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
February 11, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Requests for New Regulated Health Professions (General)

### TOPIC

The Ministry of Health receives numerous requests each year from occupations seeking to be regulated under the *Health Professions Act* (HPA) as a designated health profession (e.g. physicians' assistants, behavioural analysts, athletic therapy, manual osteopaths, genetic counsellors, etc.)

### CURRENT SITUATION

- Prior to 2002, the Health Professions Council (HPC) investigated requests for self-regulation by health care practitioner groups seeking designation as self-regulated professions under the HPA. Since the discontinuation of the HPC, responsibility for reviewing requests for self-regulation has been transferred to the Minister of Health.
- On August 27, 2020, the Steering Committee on Modernization of Health Professional Regulation released its final report, *Recommendations to modernize the provincial health profession regulatory framework.*[1]
- The Steering Committee's final recommendations for modernizing the regulatory framework for health professions includes the creation of an oversight body to make recommendations on health occupations to be regulated under the HPA.
- The authority to modernize the regulatory framework rests with cabinet and the Legislative Assembly.
- Requests for designation under the HPA have been paused until modernization of the Health Profession Regulation is completed and the oversight body is established. This oversight body is intended to do the analysis and make recommendations to government on whether health occupations should be designated or note.

### KEY FACTS

- In 1990, government established the HPC to investigate applications by associations representing health care occupations seeking designation as regulated professions, and to consider any matter involving a health profession referred by the Minister.
- In 2002 the HPC was discontinued. Work formerly done by the HPC is now the statutory responsibility of the Minister and must be done by Ministry staff or contracted resources.
- Since 2004, government has moved away from considering additional 'stand-alone' single profession colleges.

<u>Designation under the HPA</u>

- Within the HPA there are provisions to enable the designation of unregulated health occupations. Section 12 (1) enables the Lieutenant Governor in Council, on the advice of the Minister, to designate a health profession for the purposes of the HPA.
- Any profession applying for designation under section 7 (1) of the HPA must make a case to the Minister that it is in the public interest to designate the health profession. The Minister may refuse to investigate an application for designation.
- Section 6 (1) of the Health Professions Designation Regulation sets out the primary criteria that the Minister must consider, and criteria which they may consider, in order for a profession to be regulated under the HPA. These include the extent to which the practice of a health profession may involve a risk of physical, mental, or emotional harm to the health, safety, or well-being of the public.
- Before any decision is made to regulate a profession, the Minister will consider a full range of options, including non-regulatory options to address the risk of harm, before identifying whether regulation is the most appropriate way to protect the public from harm.
- Statutory regulation, such as regulation under the HPA, is typically only considered when the risk of harm cannot be proportionately managed through other means.

[1] https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/recommendations-to-modernize-regulatory-framework.pdf

Steering Committee's Final Recommendations

(see **Fact Sheet 'Health Profession Modernization'** for more details)

- The Steering Committee recommends the oversight body perform the following duties pertaining to requests for new regulated health professions under the HPA:
    - Review and make recommendations to the Minister for unregulated occupations to become regulated based on the level of risk the occupation's activities have on public health. If the Minister accepts a recommendation for regulation under the HPA, it would go to cabinet for final decision.
    - Assess certain existing regulated professions not regulated under the HPA (such as emergency medical assistants and social workers) and make recommendations whether the public interest could be better served if they were to be regulated under the HPA and, if so, by which regulator.
- The Steering Committee also recommends that the oversight body prioritize review of social workers, counseling therapists and emergency medical assistants for regulation under the HPA.
- Government continues to receive a number of requests each year for information regarding application to be considered for designation as a new health profession (e.g. physicians' assistants, behavioural analysts, athletic therapy, manual osteopaths, genetic counsellors, among others).
- Those requesting regulation are being advised to hold those requests until the modernization work is complete.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

February 11, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Resident Doctors of BC Collective Agreement

### TOPIC

The Resident Doctors of BC (RDBC) and the Health Employers Association of BC (HEABC) 2019-2022 Collective Agreement.

### CURRENT SITUATION

The RDBC and HEABC reached a tentative agreement on March 16, 2019 and the agreement was fully ratified on May 8, 2019. The agreement was reached under the 2019 Sustainable Services Negotiating Mandate.

### KEY FACTS

- The collective agreement between the Resident Doctors of BC and HEABC covers 1,359 residents and represents an estimated $100 million in annual expenditure on compensation.[1]
- Members of Resident Doctors of BC are medical school graduates participating in a postgraduate medical education training program administered by the University of BC Faculty of Medicine (FoM). Residents have earned a medical degree and must complete an additional two to five years of training at the post-graduate level before they are able to practice without the supervision of a fully licensed physician.
- The nature of the workforce represented by RDBC is distinct from the other unions in health care. Its members are employed solely for completion of a medical residency program, tenure is limited, and the FoM has substantial managerial control over their work; including, assignment of duties, scheduling and site assignment, academic performance and termination from a program.
- Residents provide direct and primary patient care as well as in-hospital care on nights and weekends.

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

- Highlights of the new collective agreement include:
  - Three-year term (April 1, 2019 to March 31, 2022)
  - General wage increases of 2% annually;
  - Commitment to deliver occupational health and safety training;
  - Initiatives to strengthen resident leadership positions; and
  - Improved oversight of on-call scheduling and workload management.
- In addition to the collective agreement, the Ministry provided $500,000 over the term of the agreement to support resident engagement initiatives.
  - The first engagement initiative between residents and Ministry representatives was held on November 20, 2019 in Vancouver. The event was well attended, with over 30 resident physicians and their guests participating in a conversation that focused on Primary Care Networks and the work that the Ministry and its partners are doing transform primary care in B.C.
  - A second engagement session with residents and Ministry representatives was held on February 13, 2020 in Victoria. Over 35 resident physicians participated, and the conversation continued with the topic of Primary Care Networks. Additionally, there was key interest in learning more about the Ministry's Virtual Care Strategy and how Virtual Care is expected to align with the PCN initiative.
  - Due to Covid-19, all future in person engagement sessions were placed on hold.
  - However, to continue the momentum and engagement with residents, the Ministry hosted a live Skype Webinar session on the *Ministry's Virtual Care Strategy/Framework,* on May 20, 2020.
  - Over 40 residents signed up for this first virtual session, and the Ministry of Health's Director of Virtual Care delivered a comprehensive presentation on Virtual Care.
  - Follow-up sessions included a focus on the ministry's COVID response on October 8, 2020 and on Primary Care Networks physician contracts on December 2, 2020.
  - The goal behind the engagement funding is to build an effective and useful relationship between the Ministry and BC's resident physicians and support the retention of these physicians after completion

[1] PSEC Compensation Annual Forecast 2019 (unreleased). p.33

of their residency. In addition to the sessions identified above, the Ministry and Resident Doctors of BC are currently discussing other initiatives that will support resident engagement.

## FINANCIAL IMPLICATIONS

The current Resident Doctors of BC collective agreement represents an estimated $100 million in annual expenditure on compensation. A 1% increase in compensation represents approximately $1 million.[2]

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**Approved:**
January 25, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 4, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[2] PSEC Compensation Annual Forecast 2019 (unreleased). p.33

# LEGISLATIVE SESSION FACT SHEET

## Single-Site Staffing Initiative

### TOPIC

As a result of COVID-19 outbreaks in long-term care facilities, Orders were issued under the *Public Health Act* and the *Emergency Programs Act* that prohibit staff from working at multiple long-term care (LTC), assisted living (AL), stand alone extended care (SAEC) hospitals, and provincial mental health facilities (PMHF).

### CURRENT SITUATION

- As of June 1st 2021 there have been 4,276 cases of COVID-19 across 202 outbreaks at approximately 149 LTC facilities in BC (some LTC facilities have had more than one outbreak), with 2,586 residents and 1,688 staff infected (2 cases are unknown). There have been 780 COVID-19 related deaths; all residents.[1]
- The Ministry of Health has drafted a document to guide employers on operationalizing the Single-Site Staffing Initiative, titled "Guidance for Employers: Operationalizing the Single Site Model"
- An amendment to the Provincial Health Officer (PHO) Order, dated October 26, 2020, allows employers to deploy or redeploy staff to facilities in accordance with provisions set out in the Guidance Document.
- The Ministry continues to work with health authorities to ensure consistent enforcement of situations where facility staff fail to comply with the requirement to work at only a single facility.

### KEY FACTS

- Most serious and fatal cases of COVID-19 in BC have been related to outbreaks in LTC facilities. A key contributor to outbreaks among vulnerable populations in LTC facilities has been health care staff infected with the virus working at multiple facilities and spreading the virus between facilities.
- On April 10, 2020 the Minister of Public Safety and Solicitor General issued an *Emergency Program Act* Order, the "Health Care Labour Adjustment (COVID-19) Order," (EPA Order) to accompany an Order issued under the *Public Health Act* (PHA), the "Facility Staff Assignment" Order (PHO Order; amended April 15, 2020).
    - The PHO Order restricts staff to working at only a single LTC, AL, PMH, or SAEC site and does not apply to dieticians, medical laboratory technologists, medical laboratory assistants, nurse practitioners, paramedics, pharmacists, physicians, resident physicians, speech language pathologists, inter-facility transport staff, delivery persons, trades people, regular and biochemical waste removal people, biomedical engineers, visitors or any other person or class of person who are exempted by the medical health officer.
    - The PHO Order is in place until rescinded by the Provincial Health Officer and the EPA Order is in place until it is set to expire.
- The accompanying EPA Order has two functions. It directs employers who are: (a) not HEABC members; and (b) subject to (existing or future) PHO or MHO orders that prohibit work by employees at more than one LTC, AL or PMH facility, to implement the specific provisions of Single Site Transition Framework (SSTF);
    - The SSTF was negotiated by HEABC, on behalf of its members and the Ministry, with the Community Bargaining Association, Facilities Bargaining Association, Health Sciences Professionals Bargaining Association and Nurses' Bargaining Association mitigate labour and employment risks.
- The EPA order also commits the Ministry (on behalf of the province) to compensate employers (including non-HEABC members) for any amount they pay in increased wages, incremental employer benefit costs and employer health tax obligations to level all employees up to union wages in accordance with the SSTF.
    - To facilitate the process, employers were directed to input staffing data to the BC Health Staffing Site, to track employees working at their various sites and record site preferences.
- The EPA Order was re-enacted as an EPA instrument under the *Covid-19 Related Measures Act (CRMA),* which is set to expire on July 10, 2021. It is anticipated the *CRMA* will be extended, though final decision on this has not been made at time of writing,

[1] Eric Larson, Executive Director, HSIAR (June 3rd, 2021).

- On June 18, 2020 it was announced staff assignment directives have been issued and single site staffing has been implemented at 100% of the 503 sites in-scope of the PHO/EPA Orders.[1]
    - 100% of the 8,878 employees previously working at multiple impacted sites, have been assigned to work at a single site.[1]
    - Employee preference has been considered where possible in staffing assignment.
- Individual wage increases have been retroactive (as appropriate) to the date a site was placed under a single site staffing order by the regional MHO and/or the PHO.
- Sustainment and monitoring of compliance is supported though continued monthly data collection via the BC Health Staffing website.

Background:

- On March 26, 2020, the PHO ordered the collection of staff data from LTC, AL, PMHF and SAEC employers, contractors and subcontractors. In support of this work, the Ministry contracted Appnovation Technologies to set up the BC Health Staffing Site, which serves to collect the data necessary to implement the initiative.

Advice/Recommentations; Legal Information

- While the Hospital Employees' Union, BC Nurses' Union and BC Government Employee's Union represent the majority of employees who are subject to the PHO order; a significant portion of the employers covered by the PHO order are non-HEABC employers, including service providers operating in health authority facilities.
- Approved funding is time-limited based on the duration of the single worksite restriction period and is being advanced to the individual facility by the health authority on a quarterly basis.

## FINANCIAL IMPLICATIONS

- Of the 506 sites in-scope of the PHO/EPA Orders, 376 sites have staff who are eligible for wage-leveling top-ups. In fiscal 2020/21 $141.5M has been provided for wage-leveling costs. Government contract with Appnovation to support the development of the BC Health Staffing site, ongoing data collection, and monitoring through to August 31, 2021.
- To support data collection and the BC Health Staffing site, Government Financial Information

Government Financial Information

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**Approved:**

June 2, 2021 – Kerri Harrison obo Philip Twyford, ADM Finance and Corporate Services Division
June 3, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

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Advice/Recommentations; Legal Information

# LEGISLATIVE SESSION - FACT SHEET

## Spiritual Care and Spiritual Health Professionals

### TOPIC

- Spiritual health represents a wide range of religious, spiritual, and philosophical world views. In BC, spiritual health is intended to help individuals and families facing health challenges to find personal meaning according to their beliefs, and when possible, return to a state of health and balance more quickly. It is an important component of a patient-centred approach to care in BC's health system.
- Unlike the historical role of pastoral care, spiritual health is not a faith-based philosophy grounded in a single religion or belief system, but instead a clinical approach to integrating an individual's world view and spiritual needs into a holistic approach to their health.
- *Spiritual Health – A Framework for British Columbia's Spiritual Health Professionals* (SHPs) was approved in January 2013, and identifies the vision, purpose, role, competencies, education, qualifications, and supports that will facilitate the recognition of spiritual health as an important component of BC's health care system. Prior to the Framework, there were no provincial qualification standards (formal education, clinical education, clinical experience) or core competencies for SHPs in BC.
- The Framework also sets a vision for spiritual health in the province, defining the purpose of spiritual health within the healthcare sector and spiritual health roles within the health system.
- The Framework identified the need for a provincial Spiritual Health Advisory Council (the Council), which met for the first time in 2013. While active, the Council provided input to the Ministry of Health on the state of spiritual care in BC and advocated that Government's commitment to Spiritual Health be fully achieved as a matter of priority. Council membership included one representative from the Canadian Association for Spiritual Care, one representative from the Denominational Health Association, and one representative from each health authority, inclusive of First Nations Health Authority.
- The decision to wind down the activities of the Council in 2018 was followed by a request to health authorities to continue to work on implementation of the Framework and to address spiritual health capacity, as those issues were of primary concern in Council meetings over its final year.

### CURRENT SITUATION

- SHPs are unregulated health workers that provide spiritual services in a variety of work settings, including health care facilities, pastoral counseling centres, prisons and correctional facilities.
- As of November 2018, there are approximately 44 FTE positions that are funded by health authorities and/or by faith communities.[1] Staffing levels by health authority are as follows (note – vacancies not displayed):

**Total Numbers of FTE SHPs by Category[2]**

| Health Authority | Educators | Leads | Practitioners | Total |
|---|---|---|---|---|
| PHSA | 0.5 | 0.5 | 2.4 | 3.4 |
| FHA | 0.5 | 0.5 | 7.9 | 8.9 |
| VCH | 0.5 | 0.5 | 6.5 | 7.5 |
| PHC | 0.8 | 1.0 | 13.7 | 15.5 |
| VIHA | 0 | 1.0 | 4.4 | 5.4 |
| NHA | 0 | 0.5 | 0 | 0.5 |
| IHA | 0 | 1.0 | 1.35 | 2.35 |

- The Framework established new educational requirements for SHPs. Currently, SHPs in BC must have a master's degree in theology, pastoral studies, or spirituality, or an equivalent combination of education and/or experience (as there is neither regulatory body nor statute that guides educational requirements, therefore the health care system must consider equivalencies to the educational standard).
- Given the small number of providers, equivalencies allow flexibility within the system to hire SHPs that may not have the educational requirements but have significant experience in SHP practice. The inclusion of

[1] Email correspondence from each Health Authority to the Ministry of Health, November 2018. Emails on file.
[2] ibid

equivalencies in the Framework was considered particularly important for aboriginal and smaller communities where it is difficult to attract higher qualified individuals and access to Clinical Pastoral Education (CPE) may be a challenge.

## KEY FACTS

- *Spiritual Health – A Framework for British Columbia's Spiritual Health Professionals* was a joint effort between the Ministry, health authorities and the Canadian Association for Spiritual Care and was finalized in 2013. It identifies the vision, purpose, role, competencies, education, qualifications, and supports that will facilitate the recognition of spiritual health as an important component of BC's health care system. Prior to the Framework, there were no provincial qualification standards (formal education, clinical education, clinical experience) or core competencies for SHPs in BC.
- Implementation of the Framework is ongoing within health authorities. The Ministry is currently working with Providence Health and Fraser Health to explore possible improvements to Clinical Pastoral Education access throughout BC, as it is currently only available in the lower mainland and poses a barrier to SHPs meeting the educational standards outlined in the Framework.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
February 11, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Status of Hiring for Primary Care Initiatives

### TOPIC

An overview of hiring status and actions to address hiring and recruitment issues for Primary Care Networks (PCNs), First Nations Primary Care Clinics (FNPCC) Nurse-Practitioner Primary Care Clinics (NPPCCs), Community Health Centres (CHCs), and Urgent and Primary Care Centres.

### CURRENT SITUATION

- As of March 4, 2021 (Period 12 of Fiscal Year 2020/21), 442 FTEs[1] have been hired, including:
  - 232 FTEs hired across 21 Primary Care Networks (PCNs) in Year 2 of implementation (9 communities)
  - 156 FTEs hired across 18 PCNs in Year 1 of implementation (12 communities)
  - 6 FTEs hired across four PCNs in Planning
  - 28 FTEs hired across three Nurse Practitioner Led Primary Care Clinics (NP-PCCs)
  - 12 FTEs hired into one Community Health Center (CHC)
  - 10 FTEs hired into one First Nations led Primary Health Centre (FN-PHC)
- Primary care initiatives are on track for fiscal year 2020/21. 39% of 1127 approved FTEs have been hired.
- As of March 4, 2021 (Period 12 of Fiscal Year 2020/21), 224 FTEs of clinical resources are staffed across 20 Urgent and Primary Care Centers, including permanent full-time and part-time resources, clinical rotations, locums, and casual staffing.
  - UPCCs currently report on FTEs on a period basis by calculating the number of hours staffed in the period and dividing that by the FTE for each occupation.
  - The Ministry is not currently able to distinguish between FTEs staffed by regular hired resources and FTEs staffed by casuals, staff rotating in from the community for select shifts, etc.
  - The Ministry is supporting UPCCs to transition to reporting on hiring of regular resources through the PCN web form so that data is comparable across all primary care initiatives in the province.
- The Ministry is taking action to address workforce challenges across primary care, including:
  - Working with Doctors of BC to support the roll out a PCN service contract for FPs with an existing patient panel and harmonizing the contracts for new-to-practice and existing FPs (now available to physicians through an expression of interest process),
  - Implementing a web portal for PCNs to use to track hiring and identify challenges;
  - Rolling out the Primary Care Clinical Pharmacist role to support PCNs;
  - Working with Health Match BC to develop a comprehensive PCN recruitment campaign;
  - Engaging with PCNs regularly to address hiring and implementation challenges;
  - Developing a Provincial Health Workforce plan with specific actions to address primary care workforce and recruitment challenges;
  - Convening a provincial advisory group to champion sustainable team-based care in BC.

### KEY FACTS

- 18 PCNs in 9 communities are in year two (2020/21) of implementation:
  - Fraser: Burnaby (3); Fraser Northwest (4); Ridge Meadows (2)
  - Interior: Kootenay Boundary (1); South Okanagan Similkameen (1)
  - Northern: Prince George (1)
  - Vancouver Coastal: Richmond (3); Vancouver CHSAs 1 and 6 (2)
  - Island: Comox Valley (1)
- 21 PCNs in 12 communities are in year one (2020/21) 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)

[1] All hiring data are drawn from the HSAIR PCN Web Form (AHIP.PCN).

  - Vancouver Coastal: North Shore (3); Vancouver CHSAs 2-5 (4)
  - Island: Cowichan Valley (1); Oceanside (1); Saanich Peninsula (1); Western Communities (1)
- Other Primary Care Initiatives:
  - Fraser: Surrey (NP-PCC)
  - Vancouver Coastal: Vancouver (RISE CHC; Lu'ma Medical Center); Powell River (Early Draw NP); Pemberton (Early Draw NP); Whistler (Early Draw NP)
  - Vancouver Island: Nanaimo (Nanaimo NP-PCC); Victoria (Victoria NPPCC; Early Draw NPs)
  - Northern: Dawson Creek (Early Draw NPs)
- Across year one and year two PCNs and the other primary care initiatives listed above, as of March 4, 2021:
  - 23 FTEs of Family Physicians (FPs)
    - 36 FPs on PCN Service Contracts (21 FTEs)
    - 3 FPs on Group Contracts in PCNs (2 FTEs)
  - 106 FTEs of Nurse Practitioners (NPs)
    - 101 NPs on PCN Service Contracts (92 FTEs)
    - 17 NPs on health authority salaries (14 FTEs)
  - 111 FTEs of Nursing Resources
    - 121 Registered Nurses (108 FTEs)
    - 5 Community Health Workers (2 FTEs)
    - 1 Licensed Practical Nurse (1 FTE)
  - 123 FTEs of Allied Health Providers
    - 20 Clinical Counsellors and 1 Counselling Group Contract (22 FTEs)
    - 2 Clinical Pharmcists (2 FTEs)
    - 7 Dietitians (5 FTEs)
    - 6 Lifeskills Workers (4 FTEs)
    - 12 Mental Health and Substance Use Clinicians (11 FTEs)
    - 9 Occupational Therapists (8 FTEs)
    - 15 Physiotherapists (9 FTEs)
    - 60 Social Workers (55 FTEs)
    - 9 other Allied Health Providers (7 FTEs)
  - 72 FTEs of Administrative Support Staff and PCN Managers
  - 7 FTEs of Indigenous Health Resources including elders, traditional healers, and health coordinators
- As of March 3, 2021, the Ministry has announced 24 UPCCs across the province, 21 of which are operational (224 clinical resources staffed at Period 12 of FY20/21).
  - Fraser: Abbotsford; Edmonds; Port Moody; Ridge Meadows; Surrey Newton; Surrey North Whalley
  - Interior: Castlegar; Kamloops; Kelowna; Vernon; West Kelowna
  - Northern: Prince George; Quesnel
  - Vancouver Coastal: City Centre; REACH; North Vancouver; Northeast
  - Vancouver Island: James Bay; Nanaimo; Westshore

## FINANCIAL IMPLICATIONS

To support this initiative, *Budget 2021* includes $253M over 3 years ($63M; $95M; $95M) to continue to expand team-based and urgent primary care. This builds on the funding that was previously allocated in *Budget 2018* to support the recruitment of primary care health professionals to implement team-based care (including additional GPs and NPs) and to pilot innovation hubs. *Budget 2018* year-3 allocation of $153M continues in 2021/22 as part of the Ministry's base budget.

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**Approved:**
May 31, 2021 – Kerri Harrison obo Philip Twyford, ADM, Finance and Corporate Services Division
June 9, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Supplementary Benefits Overview

### TOPIC

- The Supplementary Benefits Program (SBP) provides funding for the provision of health care services that are supplementary to those provided by medical practitioners. These include acupuncture, podiatry, physical therapy, chiropractic, naturopathy, and massage therapy.
- Limited surgical podiatry, dental, optometry and osteopathy benefits are also provided to Medical Services Plan (MSP) beneficiaries.

### CURRENT SITUATION

In 2019/20 (MSP paid date December 31, 2020), over 2.3 million supplementary services were provided including over 1.4 million optometry services and 64 thousand orthodontic, dental, oral medicine and oral surgery services[1]. BC offers more comprehensive coverage for supplementary services than most other provinces.

### KEY FACTS

- Under the SBP, the following services are budgeted as a group: acupuncture, podiatry, physical therapy, chiropractic, naturopathy, and massage therapy, as well as dentistry, optometry, surgical podiatry and osteopathy.
- The SBP also provides funding for midwifery services which are budgeted separately[2].
- Payment rates for 6 of the supplementary benefits were established by the Province. Additional agreements are in place with:
    - The BC Association of Optometrists – A Master Agreement and Payment Schedule for the period April 1, 2019 to March 31, 2022 was established. The Agreement includes additional funding for extended diagnostic testing, ocular foreign body removal, and rural outreach.
    - The BC Dental Association – A Master Agreement and Payment Schedules for the period April 1, 2019 to March 31, 2022 was established. The Agreement includes rate increases, new fee items for cryotherapy and topical photodynamic therapy as well as restructured consultation fee items.
    - The BC Osteopathic Association – A Master Agreement and Payment Schedule for the period April 1, 2019 to March 31, 2022 was established. The Agreement includes new funding to fees.
    - The Ministry and the Midwives Association of BC (MABC) attempted to reach a new Agreement through the Spring and Summer of 2020 and were unsuccessful. In August 2020, the MABC's membership voted to proceed to binding arbitration. Late in January 2021, the Ministry offered MABC a parallel path to arbitration in hopes of reaching a negotiated agreement before arbitration begins. In the meantime, the Ministry and MABC continue to work with the selected arbitrator on scheduling and next steps for the arbitration process.
- Under the MSP, the SBP provides funding for the provision of health care services that are supplementary to those provided by medical practitioners and includes:
    - A subsidy program for MSP beneficiaries receiving supplementary benefits. This subsidizes beneficiaries wishing to access 1 or more of 6 specific types of service: acupuncture, chiropractic, massage therapy, naturopathic, non-surgical podiatry and/or physiotherapy. Beneficiaries are eligible to receive a combined limit of 10 visits per calendar year summed across providers. MSP currently contributes $23 per visit[3] regardless of provider.
    - The *Medicare Protection Act* permits all of the above SB providers to charge patients a fee (balance bill) in addition to MSP payments for services.

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[1] Health Sector Information, Analysis and Reporting Division, Supplementary Benefits Monthly Report, December 31, 2020. Reference: SBQR_OHP six tables 20201231

[2] See Midwifery Fact Sheet – eApprovals #27271

[3] MSP Payment Schedule; Fee Items 00142, 00138, 09948, 00145, 09938, 00189 (Found at http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp)

  - Medically required services for both surgical podiatry services and optometry services are a benefit for all MSP beneficiaries. Routine eye exams are a benefit only to individuals 18 years of age and under, and 65 years of age and older.
  - MSP does not provide coverage for supplementary benefits received outside the province.
- The SBP also pays the professional fees associated with dental and oral surgery that is medically required to be performed in hospital. Providers may bill patients for the technical and work-up fees for the oral surgery but may not charge additional fees (balance bill) with respect to the professional fee items paid by MSP.

## FINANCIAL IMPLICATIONS

Excluding midwifery services,

- The SBP expenditure for 2019/20 was $92.9 million.
- The 2020/21 budget for the SBP program is $100.7 million.

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**Approved:**

February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 12, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Planning & Reporting Division
February 17, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Team-Based Care (TBC)

## TOPIC

A key feature of the Ministry of Health's primary and community care transformation is the deployment of interdisciplinary teams of health care providers to meet the comprehensive health needs of patients, communities and populations. This is known as team-based care (TBC). TBC in primary and community care will positively affect specialized services and acute care settings through better transitions.

## CURRENT SITUATION

- The TBC Advisory Group (TBCAG) is supporting the implementation of a TBC approach in Primary Care Networks (PCNs) and Specialized Community Service Programs (SCSPs). TBCAG has interdisciplinary membership with multiple partners across the health sector participating in developing supportive resources, sharing best practices, and ensuring equitable access to tools.
- Previous to this, this provincial TBC group was led by the General Practice Services Committee (GPSC), to ensure a focus beyond physician practices, membership was broadened, and the Ministry now leads the provincial discussion with diverse partners.
- To support the transition to TBC with patient and providers as partners, the TBCAG has developed resources for all members of the health-care team. This includes a website hosted by the BC Patient Safety & Quality Council which provides a one-stop portal for TBC communications and supports.
- In September 2020, TBCAG launched social media and virtual interactions to support TBC initiatives including a webinar series aiming to connect individuals and teams in identifying and sharing TBC tools and experiences.
- In implementing the TBC approach, the TBCAG relies heavily on in-kind support from both internal and external partners in areas including communications, public engagement, and technical resources.
- Recent activities of the TBCAG is to determine areas of opportunity at the system, community, team and provider levels. Focus Area Working Groups provided key recommendations for implementation. A work plan using a Collaborative Impact approach leveraging partner resources is now underway.

## KEY FACTS

- Interdisciplinary TBC is the provision of comprehensive health services to individuals, families, and/or their communities by health care providers who work collaboratively alongside patients, families and caregivers, and community service providers on shared goals within and across settings to achieve care that is culturally safe, effective, patient-centered, timely, efficient, and equitable.
- This approach promotes the patient voice and includes the patient as a full partner in decision making, creating better experiences (for both patients and providers), improving information sharing and understanding of patient care needs, and supporting self-management strategies for individuals, their families and caregivers.
- Implementing a TBC approach aligns with the Institute for Healthcare Improvement's concept of the Triple Aim by improving patient and provider experience, focusing on the health of populations and reducing per capita costs. It also fits the World Health Organization's (WHO) principles of primary health care; and the Institute of Medicine's aims for improvement of the health care system.
- In addition to the WHO, the Canadian Foundation for Healthcare Improvement, Conference Board of Canada, College of Family Physicians of Canada, Canadian Nurses Association and many other agencies support a TBC approach to health services delivery.[1]
- There is increasing evidence to support the effectiveness of team-based models of care to achieve positive patient, provider and system level outcomes.[2] Establishing interdisciplinary teams will better meet the care

[1] Canadian Foundation for Healthcare Improvement/Canadian Nurses Association. Retrieved from: www.cfhi-fcass.ca/PublicationsAndResources/ResearchReports/ArticleView/12-06-27/0f362096-8b8e-4f67-b2c0-65f6e95b2bdf.aspx;
College of Family Physicians of Canada, http://patientsmedicalhome.ca/files/uploads/BAG_TeamBasedCare_ENG-1.pdf; World Health Organization, www.who.int/hrh/resources/IPE_SixCaseStudies.pdf?ua=1
Conference Board of Canada,www.conferenceboard.ca/press/newsrelease/14-03-10/Health_Care_Team_Model_Best_For_Patients_And_Health_Care_System.aspx

[2] Virani, Tazim. *Interprofessional Collaborative Teams*. Centre of Health Service Research Foundation (2012). Retrieved from: https://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/Virani-Interprofessional-EN.sflb.ashx

needs of both individual patients across the life span (i.e., staying healthy, getting better, coping with illness and disability, and end of life) and population health needs by providing equitable access to quality and coordinated health care services at sustainable per capita costs, and as close to home as feasible.

- Supporting providers to work collaboratively as part of a team can encourage retention of existing providers, decrease burnout, and attract new providers, which is particularly important in communities where people are having difficulty attaching to a regular primary care provider, and for marginalized and vulnerable populations.
- Teams can include but are not limited to: Family Physicians (FPs), Nurse Practitioners (NPs), Registered Nurses (RNs), social workers, physiotherapists, dietitians and other providers working collaboratively in response to patient care needs. Team size and composition will be dependent on patient and community health needs.

**Ministry Strategic Alignment**

- The Ministry's TBC Policy directive, updated in August 2020, affirms effective health care delivery in the BC health system requires collaboration and coordination of care by multiple health care disciplines on behalf of the patient, and outlines definitions and provincial guidelines for establishing effective health care teams.
- TBC is a critical feature of the Ministry's strategy to increase access to primary and community care services, including the introduction of PCNs, SCSPs, Urgent and Primary Care Centres (UPCCs), NPs -Primary Care Clinics, and Community Health Centres.

**Health System Linkages to Support Implementation**

- BC Patient Safety and Quality Council is providing support for change management for primary care renewal, including assessing readiness for change; and building capacity of PCNs to implement TBC.
- UBC Innovation Support Unit is collaborating with the Ministry to undertake team mapping with PCNs to determine the functions and most appropriate team members required to meet patients needs. UBC will also be supporting PCN engagement and capacity building to implement an evidence-informed approach to TBC.
- GPSC Practice Support Program offers TBC small group learning sessions, modules, and coaching.
- Health authorities (HAs) deploy TBC supports regionally to determine local needs through partner engagement.

**Ministry Interdisciplinary Team-Based Care Initiative**

- The new integrated model of primary and community care is being established through PCNs and associated PCN clinical service models including Patient Medical Homes and UPCCs, linked with SCSPs across the province (See *Primary Care Network* FS).
- Targeted funding for net new NPs, FPs, RNs, and Allied Health Professionals (AHPs) is an integral component to integrating TBC in primary health care delivery in BC.
- NPs and FPs have been implemented on independent contracts administered through the regional HAs. Each contract has overhead included as part of the contract. RNs and AHPs are employed by the HA and deployed to the identified clinics wanting to build teams.
- Expansion of TBC will continue to require adding team members to family practices and HA primary care clinics to form in-practice teams, and networking clinics and providers into groups that work together as part of a broader community-based team. Teams are designed using population data and evidence-informed approaches to care and will be sustained by quality improvement strategies to optimize collective competence, scopes of practice, and team productivity. Team design will consider the patient voice, cultural safety and humility, choice and representation to anchor team behaviours, and reflect a culture of person-centeredness.
- The Ministry is also working in partnership with the Ministry of Advanced Education, Skills and Training, Regional HAs, and post-secondary institutions to assess the current state of inter-professional education and are considering the development of provincial guidelines/standards to support practice-readiness to adopt TBC.

## FINANCIAL IMPLICATIONS

- To support this initiative government announced in the 2018/19 budget, a net new $221 million over 3 years to support the recruitment of additional GPs and NPs to full-service family practice, and an additional $125 million over 3 years for net new primary care health professionals to implement team-based care.

- Annual funding of $151 million is part of the Ministry's base budget and continues over the next 3 years of the fiscal plan ; and $1.7 million in 2020/21 to the UBC Innovation Support Unit for work on TBC, network mapping, primary and community care transformation, and learner integration into new primary care settings.

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**Approved:**
February 3, 2021 – Kerri Harrison OBO Philip Twyford, ADM, Finance and Corporate Services Division
June 7, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Traditional Chinese Medicine and Acupuncture - Exams/Scope of Practice

### TOPIC

There are currently 2 issues related to Traditional Chinese Medicine and Acupuncture (TCMA) in BC:

1. The discontinuation of national TCMA examinations in simplified or traditional Chinese language in 2024, due to the cost of translation. Thereafter, the exams will be available in English only.
2. Requests from associations of TCMA practitioners for regulatory change and expanded scope of practice.

### CURRENT SITUATION

**Examinations**

- The Canadian Alliance of Regulatory Bodies of Traditional Chinese Medicine Practitioners and Acupuncturists (CARB-TCMPA), founded in 2012, is the organization that develops and administers the registration examinations for TCM and acupuncture. This has included the provision of exams in Chinese for BC students.
- In December 2020, CARB-TCMPA decided that, in BC, the TCMA exams will no longer be offered in simplified Chinese and traditional Chinese after October 2021, pointing to the cost of exam translation fees.
    - The CARB-TCMPA decision is reflected on page 19 of the CARB-TCMPA's Candidate Handbook, at: https://carb-tcmpa.org/wp-content/uploads/2020/04/CARB-TCMPA-Candidate-Handbook.pdf.
    - This decision applies to exams for the 3 professions of TCM practitioner, acupuncturist, and herbalist. Dr. TCM examinations are offered in BC and are not affected by the CARB-TCMPA decision.
- The BC College of Traditional Chinese Medicine and Acupuncture (CTCMA) received letters from registrants, TCMA associations and educators requesting the CTCMA continue to offer the exams in Chinese. An online petition has been signed by 2,000+ people.
- The Ministries of Health (MoH) and Advanced Education and Skills Training (AEST) also received letters from TCM practitioners, associations and MLAs, and the Minister of Health met with MLA Henry Yao in February.
- The discontinuation of the Pan-Canadian Entry-level Examinations in Traditional Chinese Medicine and Acupuncture in Chinese was to be a subject of discussion at the March 7, 2021 CTCMA Board meeting. In the interim and to inform its March 7, 2021 discussion, the CTCMA Board initiated the following:
    1. held a consultation session on February 10, 2021 with 9 stakeholder organizations;
    2. surveyed registrants (including student registrants) to obtain their perspectives; and
    3. surveyed BC TCM schools to confirm the number of existing students likely to graduate and seek to write the national exam in Chinese.
- In February 2021, the BC Association for Traditional Chinese Medicine and Acupuncture Practitioners (ATCMA) requested the AEST provide grant funding to enable the small proportion of TCMA students to complete their exams in Chinese.
- The request for funding was considered by AEST and MoH, in consultation with CTCMA and CARB-TCMPA.
- On March 26, 2021, the CTCMA posted an announcement on its website indicating current students will be able to take their examinations in simplified or traditional Chinese in 2022 and 2023, thanks to a one-time $175,000 grant from the BC Government.
- The BC Government grant is expected to benefit more than 120 students planning to write their entry-level exams in Chinese over the course of the 2022 and 2023 academic years.

**Scope of Practice**

Advice/Recommentations

- The ATCMA request follows a February 12, 2021 meeting between the MoH and TCMA associations to discuss regulatory modernization, during which the MoH explained requests for amendments to regulations and scope of practice must wait until modernization and college amalgamations are completed.
- At the February 12, 2021 meeting, the MoH also explained that many health professions are awaiting MoH consideration of proposals submitted to amend/expand their scope of practice.

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

**Examinations**

- Prior to the 2012 formation of CARB-TCMPA, the CTCMA administered the exams for BC students.
- At the CTCMA 2011 Annual General Meeting in January 2012, 2 resolutions were passed by the assembly: 1) the CTCMA not set up language barriers for the practice of TCM in the form of a minimal English or minimal Chinese proficiency requirement; and 2) all exams and mandatory courses administered by CTCMA be available in both Chinese and English. AGM resolutions are not binding for the CTCMA.
- The cost to CARB-TCMPA for a student to write the Chinese language 2021 exam is between $5,000 and $5,700, with translation fees comprising about $4,500 of that per-student amount.
- The cost to a BC student wishing to write the Chinese language 2021 exam is a total of $1,910 ($300 application, $1,210 examination, $400 Chinese translation).
- As of March 2, 2021, there are 446 student registrants in BC programs (the actual number may be higher as student registration is not required in the first semesters of most programs).
- The number of BC TCMA students writing the exams in Chinese has declined from 84 in 2016 to 51 in 2020.
- The CTCMA has provided direction to TCM practices that, for seamless patient care/referral and safety, the TCM or acupuncture practitioner must ensure there is someone present in their practice with the ability to communicate in English to the patient and with other providers/services in the health care system.

**Scope of Practice**

- The CTCMA is 1 of 5 regulatory colleges whose regulations have not yet been updated to fully align with the HPA's Shared Scope of Practice/Restricted Activities Model. Completion of this has been on hold while regulatory modernization is underway, including the anticipated amalgamation of regulatory colleges.
- On December 4, 2020 the CTCMA posted a Notice on Point Injection Therapy (PIT) on its website, indicating that while a proposal to amend scope of practice had been filed with the MoH in 2015 (updated in 2017), in the absence of a regulatory amendment the administering of injectables (including intravenous injections) is not within the current scope of practice for TCM practitioners and acupuncturists in BC.
- The restricted activity of administering an injection (including PIT and intravenous injection therapy) is not in the foundational education or CARB-TCMPA competencies for TCM practitioners/acupuncturists, raising questions of safety. As well, there is limited evidence to support the efficacy of PIT and intravenous injection therapy.
- When considering changes to the scope of practice for regulated health professions, the MoH will first consider "*what is the problem we are trying to solve?*" If health delivery system issues are identified, other non-regulatory solutions are considered before contemplating regulatory changes to expand scope of practice.
- When scope of practice changes are contemplated, significant policy work is required to support any possible expansion. This includes cross-jurisdictional scans, assessment of education and training of health professionals, extensive consultation with stakeholders including the public and other health regulators, risk assessment, etc.
- The MoH has many competing priorities, including regulatory modernization and the two public health emergencies, and any request for regulatory change is considered in relation to those priorities.

## FINANCIAL IMPLICATIONS

**Examinations** - In 2020/21 the Province provided the CTCMA with $175,000 to support the offering of exams in Simplified and Traditional Chinese.

**Scope of Practice** - An estimate of the financial implications for an amended scope of practice for TCM practitioners and acupuncturists has not been completed and would form part of a future policy analysis if undertaken.

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**Approved:**

April 30, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM and CFO, Finance and Corporate Services Division
June 1, 2021– Mark Armitage, Health Sector Workforce and Beneficiary Services Division

# FACT SHEET

# Traditional Chinese Medicine and Acupuncture in BC

## TOPIC

The practice of Traditional Chinese Medicine (TCM) means the promotion, maintenance and restoration of health and prevention of a disorder, imbalance or disease based on traditional Chinese medicine theory, by utilization of the primary therapies of:

- Chinese acupuncture (Zhen), moxibustion (Jiu) and suction cup (Ba Guan);
- Chinese manipulative therapy (Tui Na);
- Chinese energy control therapy (Qi Gong);
- Chinese rehabilitation exercises such as Chinese shadow boxing (Tai Ji Quan); and
- Prescribing, compounding or dispensing Chinese herbal formulae (Zhong Yao Chu Fang) and Chinese food cure recipes (Shi Liao).

## CURRENT SITUATION

Current issues related to TCM and acupuncture, regarding the discontinuation of examinations in Chinese and the request to amend scope of practice, are addressed under a separate fact sheet titled Traditional Chinese Medicine and Acupuncture: Exams and Scope of Practice.

## KEY FACTS

- The College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia (CTCMA) is the regulatory body established for the health professions of traditional Chinese medicine (TCM) and acupuncture.
- Acupuncture has been a designated health profession under the *Health Professions Act* (HPA) since April 1, 1996.
- TCM has been a designated health profession under the HPA since December 4, 2000.
- Before designation under the *Health Professions Act*, these professions were unregulated in BC.
- The TCM and acupuncture professions are regulated by the CTCMA in accordance with the HPA, the Traditional Chinese Medicine Practitioners and Acupuncturists Regulation (which sets out scope of practice) and the bylaws of the CTCMA.
- The CTCMA is one of eight regulatory colleges whose regulations have not yet been updated to fully align with the HPA's Shared Scope of Practice/Restricted Activities Model. (For more information on TCM practitioner and acupuncturist scope of practice see the fact sheet titled Traditional Chinese Medicine and Acupuncture: Exams and Scope of Practice.)
- There are currently 1,911 registrants across the four reserved titles of acupuncturist, doctor of traditional Chinese medicine, traditional Chinese medicine herbalist, and traditional Chinese medicine practitioner[1].
- Kwantlen Polytechnic University (KPU) offers a TCM Acupuncture diploma program, which operates without funding from government. KPU has signed a general Memorandum of Understanding with Beijing University of Chinese Medicine.
- In addition to KPU, there are seven[2] private institutions in BC that offer CTCMA-recognized TCM education programs, which are acceptable to the Private Training Institutions Branch of the Ministry of Advanced Education, Skills and Training. Two of the eight private institutions offer programs in Chinese. (For more information on the provision of examinations in Chinese see the fact sheet titled Traditional Chinese Medicine and Acupuncture: Exams and Scope of Practice.)
- The number of CTCMA registered practitioners has been gradually increasing each year, and the number of CTCMA registered students has remained fairly static at approximately 400+ per year.

[1] CTCMA 2019-20208 Annual Report, retrieved 2021-03-04 from https://www.ctcma.bc.ca/media/1928/annual-report-2019-2020.pdf

[2] CTCMA bylaws Schedule H retrieved 2021-03-09 from https://www.ctcma.bc.ca/media/1942/ctcma-bylaws-and-schedules.pdf

# FACT SHEET

| CTCMA Registrant Classes | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Registration Type** | **2015-2016** | | **2016-2017** | | **2017-2018** | | **2018-2019** | | **2019-2020** | |
| Doctor of TCM | 317 | 14.8% | 310 | 13.7% | 324 | 14.0% | 325 | 14.0% | 343 | 13.8% |
| TCM Practitioner | 454 | 21.1% | 498 | 22.0% | 532 | 22.9% | 567 | 24.0% | 580 | 23.3% |
| Acupuncturist | 806 | 37.5% | 846 | 37.5% | 878 | 37.8% | 917 | 38.8% | 959 | 38.5% |
| Herbalist | 33 | 1.5% | 31 | 1.4% | 31 | 1.3% | 31 | 1.3% | 29 | 1.2% |
| Student | 434 | 20.2% | 456 | 20.2% | 447 | 19.3% | 427 | 18.1% | 491 | 19.7% |
| Non-practicing | 103 | 4.8% | 118 | 5.2% | 110 | 4.7% | 110 | 4.7% | 87 | 3.5% |
| **Total practicing** | **2,044** | **95.2%** | **2,141** | **94.8%** | **2,212** | **95.3%** | **2,267** | **95.3%** | **2,402** | **96.5%** |

Source: CTCMA 2019-2020 Annual Report (data for years 2017-2018 to 2019-2020), and the CTCMA (data for years 2015-2016 to 2016-2017).

## FINANCIAL IMPLICATIONS

- For Medical Services Plan (MSP) beneficiaries receiving premium assistance, MSP contributes $23 per visit for a combined annual limit of 10 visits each calendar year for the following: acupuncture, chiropractic, massage therapy, naturopathy, physical therapy and non-surgical podiatry.
- Acupuncture services were included among the benefits of the Supplementary Benefits program effective April 1, 2008.
- Payments for acupuncture for 2019/20 were $4.4 million (paid for 2828,235 patients or 191126,269 services).[3]

**Approved:**

April 24, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
April 29, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Divisio
April 30, 2021 – Peter Klotz obo Philip Twyford, ADM Finance & Corporate Services Division

[3] Per HSIAR report for supplementary benefits at September 30, 2020 cut-off.
[3] Health Sector Information Analysis and Reporting Division, Ministry of Health, Supplementary Monthly Report – March 31, 2021 (Specialty 68)

# LEGISLATIVE SESSION - FACT SHEET

## Travel Assistance Program

### TOPIC

Medical travel assistance.

### CURRENT SITUATION

The Travel Assistance Program (TAP) helps alleviate some of the transportation costs for eligible BC residents, who must travel within the province for non-emergency medical specialist services not available in their own community.

### KEY FACTS

- Discounted travel fares are available to eligible residents through our participating travel partners including air, ferry and ground services.
- In 2004, the Ministry of Health assumed financial responsibility for TAP ferry travel subsidies. Payment is made to BC Ferries through the Ministry of Transportation and Infrastructure.
- In 2019, the Wilson's Group partnered with TAP to provide discounted fares on the BC Ferries Connector route between Victoria and Vancouver and through the VI Connector providing bus service on Vancouver Island.
- There were 128,890 approvals issued by the Ministry for the fiscal year 2019/20, a decrease of 1.8% from 2018/19.[1] Of those approvals, 98.7% were for fully subsidized ferry travel.

**Approved Confirmations by Travel Mode – April 1, 2019 – March 31, 2020**

| Mode | Number | Escort | One Way | Vehicle |
|---|---|---|---|---|
| Air | 1,668 | 736 | 203 | |
| Angel Flight | 6 | 6 | 1 | |
| Bus | 11 | 2 | 2 | |
| Ferry | 127,164 | 76,858 | 3,555 | 122,740 |
| Rail | 41 | 28 | 4 | |
| **TOTAL** | **128,890** | **77,630** | **3,765** | **122,740** |

- Of the 39,301 unique patients who obtained a TAP confirmation number in 2019/20, 43.9% were seniors and 28.1% were on Premium Assistance (table below). Of those unique patients, 85.5% obtained between 1 and 5 travel confirmations during fiscal year 2019/20, and an additional 9.7% obtained between 6 and 10 travel confirmations.[2]

**Patients by Range of Approved Confirmations – April 1, 2019 – March 31, 2020**

| Conf's per Patient | Number of Patients | % of Patients | Total Conf's | % of Conf's | Number of Seniors | % of Seniors | Number on PA | % on PA |
|---|---|---|---|---|---|---|---|---|
| 1 to 5 | 33,619 | 85.5 | 65,837 | 51.1 | 14,128 | 42.0 | 9,339 | 27.8 |
| 6 to 10 | 3,801 | 9.7 | 28,225 | 21.9 | 2,091 | 55.0 | 1,080 | 28.4 |
| 11 to 20 | 1,452 | 3.7 | 20,303 | 15.8 | 834 | 57.4 | 432 | 29.8 |
| 21 to 30 | 251 | 0.6 | 6,173 | 4.8 | 133 | 53.0 | 90 | 35.9 |
| >30 | 178 | 0.5 | 8,352 | 6.5 | 73 | 41.0 | 84 | 47.2 |
| **TOTAL** | **39,301** | **100.0** | **128,890** | **100.0** | **17,259** | **43.9** | **11,025** | **28.1** |

### FINANCIAL IMPLICATIONS

- For 2019/20, the budget was $14.5 million and expenditure at March 31, 2020 was $11.3 million.
- For 2020/21, the budget is $14.5 million.
- Due to COVID-19, travel has decreased.

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**Approved:**

January 25, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services

February 8, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

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[1] https://tap.hlth.gov.bc.ca/tap/faces/TravelAssistanceSummary.xhtml

[2] https://tap.hlth.gov.bc.ca/tap/faces/ApprovedConfirmationsPerPatient.xhtml

# LEGISLATIVE SESSION - FACT SHEET

# Unmatched Canadian Medical Graduates

## TOPIC

The number of unmatched Canadian medical graduates (CMGs) to a postgraduate medical education (PGME) residency program increased between 2015 to 2018, but has since decreased in 2019 and 2020.

## CURRENT SITUATION

- In 2020, 98% of University of BC (UBC) undergraduate medical education (UGME) graduates that applied to the Canadian Resident Matching Service (CaRMS) matched to a PGME residency program.[1]
- There are two iterations of the CaRMS match. Graduates unmatched in first iteration may apply to the second iteration. All (100%) UBC UGME graduates unmatched in the first iteration matched in the second.[2]
- To increase the likelihood of matching in CaRMS, UBC provides counseling during UGME to help guide medical students with regards to specialty areas that hold the most promise for being successfully matched.
- The UBC Family Medicine Program remains highly desirable for UGME graduates. In 2020, UBC was the only university that matched 100% of its Family Medicine PGME residency positions in CaRMS first iteration.

## KEY FACTS

National Data

- It is a lengthy, rigorous, and highly competitive process to train as a physician in Canada. Applicants to a UGME program must often apply multiple times before gaining UGME admission. In addition, applicants are also encouraged to apply to multiple schools across Canada to maximize potential for admissions.
- After completing a four year UGME program, CMGs must then compete for PGME residency positions at the national level through CaRMS, an independent, arms-length provider of a client-centred, fair, transparent, and equitable matching service for medical education in Canada.
- CaRMS provides three main reasons why an applicant may go unmatched:[3]
    - Applicant was not ranked by a program they ranked
    - Applicant did not rank a program that ranked them
    - Applicant was ranked by a program they ranked, but the program filled with a preferred applicant
- The following table illustrates nation-wide cumulative unmatched current-year CMG totals by year: [4]

| Year | # unmatched CMGs | | Year | # unmatched CMGs |
|---|---|---|---|---|
| 2015 | 39 | | 2018 | 69 |
| 2016 | 45 | | 2019 | 31 |
| 2017 | 68 | | 2020 | 25 |

    - Beyond 2018, unmatched numbers decreased to 31 (1.1%) in 2019 and then to 25 (0.9%) in 2020.[5]
    - Primary drivers for increases between 2015 and 2018 include additional competitive applicants applying from the United States and previous year unmatched CMGs competing with current year CMGs.
- National CaRMS match results in 2019 and 2020 are summarized as follows:
    - In 2019, a total of 2,881 CMGs, 391 international medical graduates (IMGs), and 22 US medical graduates matched nationally to a CaRMS PGME residency position.[6]
    - In 2020, a total of 2,895 CMGs, 418 IMGs and 28 United States medical graduates matched nationally to a CaRMS PGME residency position.[7]

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[1] CaRMS. (2020). *R1- Data and Reports.* (p.57-58). https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 19, 2021.
[2] Ibid.
[3] CaRMS (2020). https://www.carms.ca/the-match/how-it-works/what-if/#applicant-not-match. Last accessed January 21, 2021.
[4] AFMC. *The Association of Faculties of Medicine of Canada 2019-20 Annual Report*. (p. 5). 2020. https://afmc.ca/web/sites/default/files/annual-reports/2019-annualreport.pdf?2020-2. Last accessed January 18, 2021.
[5] CaRMS. (2020). *CaRMS Forum Data: Unmatched Current Year CMGs After Second Iteration* http://carms.ca/pdfs/2020-carms-forum.pdf. Last accessed January 20, 2021.
[6] CaRMS. (2019). *R-1 Data and Reports Summary Report 1*, https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 20, 2021.
[7] CaRMS. (2020) *R1 Main Residency Match* https://www.carms.ca/wp-content/uploads/2020/05/2020_r1_tbl1e.pdf. Last accessed January 20, 2021.

UBC Data

- To align with the UBC's 288 UGME graduates each year, at least 288 entry-level PGME residency positions are allocated to CMGs in the first iteration of the CaRMS.
    - In 2020, UBC posted 352 positions: 294 CMG and 58 IMG positions.[8]
    - Both CMGs and IMGs compete for unfilled first iteration positions that move to the second iteration.
- Each year UBC continues to match almost all of its UGME CMGs. The overall percentage of UBC UGME graduates that successfully matched in CaRMs (by year) is as follows:
    - 96% match rate (2018)[9]; 99% match rate (2019)[10]; 98% match rate (2020)[11]
- A small number of UGME CMGs unmatched in the first iteration choose not to apply in the second iteration of CaRMS. This may be because their desired specialty is not available in the second iteration (i.e. positions filled in the first iteraction)
    - In 2020, all (100%) UBC graduates that applied in the second iteration were matched.[12]
- As a result of Government's priority to support primary care in BC, UBC now has the largest single Family Medicine PGME training program in Canada.
    - In 2020, UBC was also the only university in Canada to fill all (100%) of its 174 Family Medicine PGME positions within the first iteration of CaRMS[13]

A Pan-Canadian Approach

- In January 2018, the Association of Faculties of Medicine of Canada (AFMC) released a report to highlight the unmatched CMG issue and proposed next steps.
    - AFMC identified a set of contributing factors, including reduced national ratio of UGME graduates to PGME positions; IMGs filling CaRMS second iteration positions; increased numbers of US UGME graduates matching to Canadian positions.
- The most recent AFMC annual report (2019/20) continues to advocate for solutions including: increase the number of PGME positions nationally; enhance and/or reserve more opportunities for CMGs in the second iteration of the match; review current entry routes to residency and provide additional supports to unmatched CMGs.[14]
- Although the number of unmatched CMGs has declined significantly over the past two years, the issue continues to be monitored on Pan-Canadian platforms including the Committee on Health Workforce.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
January 31, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division

[8] CaRMS. (2020). *R1- Data and Reports: Tables 8.* https://www.carms.ca/wp-content/uploads/2020/05/2020_r1_tbl8e.pdf. Last accessed January 21, 2021.
[9] CaRMS. (2018). *R1- Data and Reports: Tables 2 and 16.* https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 20, 2021.
[10] CaRMS. (2019). *R1- Data and Reports: Tables 2 and 16.* https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 20, 2021.
[11] CaRMS. (2020). *R1- Data and Reports: Tables 2 and 16.* https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 20, 2021.
[12] CaRMS. (2020). *R1- Data and Reports: Table 39.* https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 20, 2021.
[13] CaRMS. (2020). *R1- Data and Reports: Table 39.* https://www.carms.ca/data-reports/r1-data-reports/. Last accessed January 20, 2021.
[14] AFMC. *The Association of Faculties of Medicine of Canada 2019-20 Annual Report*. 2020. https://afmc.ca/web/sites/default/files/annual-reports/2019-annualreport.pdf?2020-2. Last accessed January 20, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Workforce Planning for Surgical Renewal

### TOPIC

To restart surgeries that were cancelled due to COVID-19 and increase surgical capacity, the Ministry of Health, health authorities, and the Health Employers Association of BC (HEABC) are collaborating to address human resource challenges and alleviate workforce pressures.

### CURRENT SITUATION

- The Ministry is working collaboratively with health sector partners to address labour issues and other challenges pertinent to the surgical workforce. This includes:
  - Health authorities and the Ministry of Advanced Education, Skills, and Training (AEST) are delivering on increased training of medical device reprocessing technicians.
  - Health authorities are ramping up specialty training for registered nurses so they can work as perioperative and post-anesthetic recovery specialists.
    - All health authorities have completed the training plans for the additional 400 nursing and 100 medical device reprocessing staff. Each health authority will add staff primarily through training, with a small number to be recruited. This training will take place over 2020/21 and 2021/22, with additional training sessions offered to accelerate training.
  - AEST, health authorities, and post-secondary institutions (PSIs) are collaborating to offer new training opportunities for anesthesia assistants.
  - The Ministry is partnering with the BC College of Nursing and Midwives and UBC to explore establishing a new nursing role working in anesthesia care as part of broader Anesthesia Care Team implementation which will enable a team based model of care with all providers working ton optimized scope of practices;
  - The Ministry is working to expedite licensing of international nursing graduates.
  - Health authorities and HEABC have significantly increased uptake of the provincial anesthesia contract.
- Additionally, the Ministry has provided Health Match BC (HMBC) with $815,000 to provide recruitment support for anesthesia, surgical nurses, and select allied health professions.
- Between April 1, 2020 and March 4, 2021, the combined efforts of HMBC and health authorities have resulted in the following resources being recruited
  - 471 perioperative registered nurses,
  - 64 perioperative licensed practical nurses,
  - 291 post-anesthetic recovery registered nurses,
  - 403 medical device reprocessing technicians,
  - 56 anesthesiologists,
  - 4 general practice anesthesia (GP-A), and
  - 51 surgeons.
- In addition, 340 perioperative and post-anesthetic recovery nurses have started their specialty training programs, and 237 have completed their programs[1].

### KEY FACTS

- To address the surgical delays caused by COVID-19, the Ministry released *"Our Commitment to Surgical Renewal"* on May 7, 2020 to restart surgical services in BC and keep up with new demand.
- Effective May 18, 2020, surgeries were restarted with direction to increase to pre-COVID levels.
- As of March 4, 2021 the Ministry has delivered surgeries to 96% of the 15,247 patients who were called during the first wave of COVID-19 and had their surgery postponed and who still wanted to pursue a surgical treatment[2].

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[1] Ibid.

[2] Data drawn from: A Commitment to Surgical Renewal Report in B.C., Progress Report #7, November to December, 2020.

- Key workforce-related actions outlined in *"Our Commitment to Surgical Renewal"* include:
  - Increasing internal training for staff, particularly perioperative nurses, to meet the need for approximately 400 additional nurses across the province.
  - Increasing the number of medical device reprocessing technicians by about 100 across the province.
  - Recruiting net new staff, including registered nurses, anesthesiologists, surgeons, and targeted allied health providers.
  - Providing greater access to regular, full-time employment for casual and part-time staff.
- The Ministry is working with health authorities and HEABC to implement a surgical renewal workforce strategy to support "*Our Commitment to Surgical Renewal in B.C.*"
  - This work leverages existing provincial health workforce planning processes to achieve targeted capacity increases and to secure an adequate supply of nurses, medical staff, allied health providers, and physicians to meet current and future demand.
  - Targeted working groups have been established to help move this work forward, including a Surgical Renewal LR/HR Steering Committee, with senior representation from the Ministry, health authorities and HEABC, and a ministry-focused surgical working group.
- Recruitment and retention working groups established under the Facilities Bargaining Association and Health Sciences Professionals Bargaining Association collective agreements have also been asked to recommend actions to secure staffing of occupations critical to surgical services.

## FINANCIAL IMPLICATIONS

The Ministry has committed to support additional recruitment activity through Health Match BC with 1-year funding of $815,000.

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**Approved:**

May 21, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
May 27, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
June 9, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Workplace Violence in Health Care

## TOPIC

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

## CURRENT SITUATION

**Provincial Framework 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 *Health Authority Workforce Violence Prevention (WVP) Policy Directive* (November 2017) is scheduled for review for the 2021/22 fiscal year, in conjunction with the Provincial Violence Prevention Policy Framework.

**Workplace Violence Prevention (VP) Training**

- As of June 14, 2021, between 82.9% of health authority staff members who work in high-risk areas and where identified as priority for VP training have completed the training.[1]
- A Physician Violence Prevention curriculum was implemented in June 2019 with 350 medical residents completing the 1.5 hour online and 3.5 hour classroom in the first year. Physicians receive continuing medical education credits upon completion.[2]

**Occupational Health and Safety Resource Centre**

- The Ministry, HEABC, key partners, and stakeholders have agreed to consolidate and provide on-line access to Joint Occupational Health and Safety Committee (JOHSC) and violence prevention resources to solve current collaboration and standardization challenges and to provide the province with a platform to support future initiatives.
- This work is being led by the transition team for the new BC Health Care Occupational Health and Safety Society (refer to Fact Sheet) who have committed $218,000 to support the work (funding is to come from previous bargaining commitments).

Advice/Recommentations; Government Financial Information

**Marchbank Report**

- In 2018 Michael Marchbank was commissioned by the Ministry to conduct a review on violence in the health sector and make recommendations. This report was completed and recommendations accepted in early 2019.
- The announcement regarding initiatives stemming from the Marchbank Report were planned for early in 2020 but were placed on hold because of the COVID 19 pandemic.

**Priority Sites**

- In 2015, the Ministry and the Nurses' Bargaining Association (NBA) committed to safety improvements at four facilities deemed high risk for violence: Forensic Psychiatric Hospital, Hillside Centre, Seven Oaks Tertiary Mental Health, and Abbotsford Regional Hospital.

[1] Data Provided: OSH solutions, August 6, 2020.
[2] Data Provided: OSH Solutions, October 8, 2019

- Assessments were conducted at each site which included recommendations for targeted action to reduce violence. Agreed upon items were implemented which included environmental modifications, increased staffing levels, upgraded communications systems and panic buttons, education, and added security.
- Building on the four sites reviewed in 2015, 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
- Assessments at all six sites were completed at the end of May 2021; Implementation of recommendations by joint employer and union working groups is expected to occur over the remainder of the fiscal 2021/2022.

## KEY FACTS

- Workplace injuries 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 2019, claims costs were more than $124 million, an increase of over $17 million from the previous year. [3]
    - From 2015 to 2019, total days lost due to workplace injuries has increased by 15% in the health care and social services sector[4].
    - 14% of reported WorkSafe BC claims within the 2015 – 2019 timeframe was for violent or aggressive behavior.[5,6]
- Health Care Assistants, a key workforce group providing home and community care services (37,399 active employees), submitted 16,341 time-loss claims in the 2015-2019 period:
    - 16% (2,626) of the time-loss claims were attributed to acts of violence, and
    - 72% (1,879) of those violence related time-loss claims occurred in long term care[7]
- In July 2019, the Ministry established a new Health Sector Health and Safety unit to work with key partners and stakeholders to lead, monitor, and report out on the progress towards reducing violence in the health care sector.
- The new *BC Health Care Occupational Health & Safety Society* (OHS) will help advance workplace violence prevention initiatives within the health sector. The OHS Society is governed by a Board of Directors representative of senior leaders appointed from stakeholder organization (six employer representatives, six worker representatives, a representative from the Doctors of BC, and an independent Chair). The Ministry and WorkSafe BC participate as ex-officio members.
- The OHS Society role and scope of responsibility for workplace violence is being considered as the Society begins its strategic planning.

## FINANCIAL IMPLICATIONS

- In August 2015, the Ministry, and the Nurses' Bargaining Association each committed $1.0 million[8] to implement violence prevention measures at four high-priority sites, all of which has been completed (noted above).
- In 2016, the Ministry committed $2.0 million[9] through the NBA agreement, to be matched by the NBA, for the purposes of taking targeted action at six high priority sites (noted above).

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[3] WorkSafeBC Statistics 2018 and WorkSafeBC Statistics 2019. Retrieved from https://www.worksafebc.com/en/about-us/shared-data/facts-and-figures/statistical-reports

[4] WorkSafeBC Statistics 2019, p. 38. Retrieved from https://www.worksafebc.com/en/about-us/shared-data/facts-and-figures/statistical-reports

[5] Aggression and violence are defined as a person's use of physical, verbal, or emotional force, either threatened or actual, which is intended to cause injury to another person. WorkSafeBC defines aggression as "hostile, unpleasant, or unacceptable behaviour that may include everything from offensive gestures or expressions to physical violence."

[6] https://public.tableau.com/profile/worksafebc#!/vizhome/IndustryclaimsanalysisTime-lossclaimsinB_C_/Didyouknow

[7] https://public.tableau.com/profile/worksafebc#!/vizhome/HealthcareassistantsTime-lossclaimsinB_C_/Didyouknow

[8] BC Nurses Union Website: https://www.bcnu.org/news-and-events/update-magazine/oct2015-mental-health

[9] BC Nurses Union Website: https://www.bcnu.org/news-and-events/update-magazine/oct2015-mental-health

# LEGISLATIVE SESSION - FACT SHEET

- The Ministry has provided $4.5 million in 2020/21 to establish the BC Health Care Occupational Health and Safety Society.
- The Ministry has committed to provide $4.0 million in 2021/22 to establish the *BC Health Care Occupational Health and Safety Society* to address workforce safety.

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**Approved:**
June 14, 2021– Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 28, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

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# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Response and Supports for Indigenous Communities in BC

## TOPIC

The Ministry of Health, First Nations Health Authority (FNHA), Indigenous Services Canada (ISC), and Emergency Management BC are the lead agencies for support to First Nations and Indigenous communities for COVID-19 mitigation, preparedness, response, and recovery.

## CURRENT SITUATION

**First Nations Impact**

- As of June 10, 2021:
  - ISC reported 3,126 confirmed COVID-19 cases in BC First Nations communities[1].
  - FNHA reported 7,331 First Nations cases, which reflect off-reserve cases, whereas ISC reports on-reserve numbers only. [2]
- Where requested, regional emergency operations calls are set up with local leadership, regional health authorities, FNHA and Emergency Management BC staff, to support a collaborative response.

**Structural Integration and Partnerships**

- FNHA is embedded into the provincial health system response to ensure full integration.
- The Office of the Provincial Health Officer (PHO) is working very closely with the FNHA Office of the Chief Medical Officer in planning and response, including data surveillance.
- BC ministries have supported political and health focused tables with First Nations Leadership Council, Nations, and communities to discuss and address First Nations interests.
- The Province and regional partners have also supported the BC Association of Aboriginal Friendship Centres and Métis Nation BC (MNBC).

**Rural and Remote First Nations and Indigenous Framework**

- The Framework[3] was established to ensure that people living in rural/remote or First Nations communities have access services during the COVID-19 pandemic and beyond, and was developed collaboratively by FNHA, Northern Health Authority, and the Provincial Health Services Authority.
- The Framework supports medical transportation, isolation supports, testing, contact tracing and access to mental-health supports in communities.
- Regional implementation plans were collaboratively developed with Indigenous partners.

## KEY FACTS

**Outbreak Management and Security from a Health Perspective**

- COVID-19 case/outbreak management is led in a collaborative way between the health authority medical health officer, FNHA, and the appropriate health leads within the Nation.
- The partners ensure measures are taken to support that outbreak management, including security measures, are made at the collaborative direction and recommendation of the partners.
- Positive cases experienced to date have demonstrated these teams coming together to enact immediate public health response, to minimize the impact of the outbreak.

**Regarding Data Access/Information Sharing**

- The details of another's care are confidential under the *Freedom of Information and Protection of Privacy Act*. Care staff are not permitted to discuss a person's health information.
- When a positive COVID-19 status First Nations case is identified in a First Nations community, the regional medical health officer is notified, who will in turn work with the FNHA Chief Medical Officer on a coordinated response.
- Notification and supports for the client, as well as contact tracing, are done in partnership between the regional health authority and FNHA Communicable Disease/health care teams.

**Office of the Information Privacy Commissioner (OIPC) Request**

[1] https://www.sac-isc.gc.ca/eng/1581964230816/1581964277298

[2] FNHA-COVID-19-Public-Health-Response-Community-Situation-Report-June-10-2021.pdf

3 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

- An information sharing request was formally submitted by Nation Counsel to the OIPC on September 14, 2020, requesting 3 items: 1) location (not the personal identity) of *proximate* presumptive and confirmed COVID case; 2) whether proximate case involves travel to one of the Nations, within the last 14 days; and 3) name of a person infected by COVID-19, who is a member of one of the Nations.
- On December 17, 2020, the OIPC concluded that "COVID-19 creates a risk of significant harm to the public and to the complainants' communities, section 25(1)(a) does not in the circumstances require the Ministry to disclose the information that the complainants argue must be disclosed" and "sufficient information is already available to the complainants and to the public…"[4]
- The BC Centre for Disease Control provides weekly updates on cases by local health area to assist in local and regional planning and added transparency while maintaining confidentialities.[5]
- In parallel, the PHO, supported by the Ministry, developed an information sharing agreement to give Nations the information they need to make informed decisions for travel and safety measures.
- An information sharing agreement has now been signed with 9 First Nations communities in this pilot phase, and data is flowing. Expansion of information sharing agreements to other communities will be visited once we have a better understanding of phase one implementation.

**Culturally Safe Contact Tracing**

- The Ministry approved funding for FNHA to allocate 97 community liaison positions to support culturally safe contact tracing with community expertise.
- Of the liaisons hired to date, many have been helping to support self-isolation in community for individuals who are isolating, including doing daily monitoring of low complexity cases.

**COVID-19 Vaccine Roll-out**

- BC's COVID-19 Immunization Plan[6] was released in January 2021 with an initial prioritization of Indigenous Peoples in remote and isolated communities, and at an age differential of 15 years to other British Columbians.
- As of March 31, 2021, all Indigenous peoples aged 18+ were eligible to receive a vaccine, and the Province worked in partnership with FNHA and other Indigenous partners to reduce vaccine hesitancy and support cultural safe vaccine opportunities.
- FNHA has reported that as of June 7, 2021, approximately 95,900 First Nations people 12+, have received one dose of vaccine; and nearly 34,000 have received two doses. As of June 7, 62.1% of all status and status-eligible First Nations people in BC age 18+ have received at least one dose of vaccine.[7]

## FINANCIAL IMPLICATIONS

- COVID-19 funding to Indigenous communities has mainly been led through the federal Indigenous Community Support Fund, with BC allocations as follows[8]:
  - $79.17 million in direct funding to BC First Nations communities; $7.5 million to MNBC;
  - $6.47 million to communities and organizations supporting urban Indigenous peoples.
- In 2019/20, the Ministry provided $80,000 in bridge funding through PHSA to MNBC to meet immediate needs related to pandemic planning including sanitizers and supplies.
- In 2020/21, the Ministry provided the First Nations Health Authority with:
  - $1.23 million to support the implementation of a public health response for COVID-19; and
  - $8.11 million to support a Rural, Remote, Collaborative Framework response for COVID-19.

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**Approved:**
March 15, 2021 –Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
April 29, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
June 14, 2021 – Breanna Chandler, ED, Office of Indigenous Health and Reconciliation
June 14, 2021 – Dawn Thomas, Associate DM, Indigenous Health

4 https://www.oipc.bc.ca/orders/3494
5 BC COVID-19 Data (bccdc.ca)
6 https://www2.gov.bc.ca/gov/content/safety/emergency-preparedness-response-recovery/covid-19-provincial-support/vaccines
7 FNHA-COVID-19-Public-Health-Response-Community-Situation-Report-April-26-2021.pdf
8 Indigenous Community Support Fund: allocations to communities and organizations (sac-isc.gc.ca)

# LEGISLATIVE SESSION - FACT SHEET

## First Nation Health Governance and Commitments

### TOPIC

The Government of BC's foundational and ongoing commitments to First Nations health and wellness, grounded in a number of tripartite and bilateral health agreements and plans.

### CURRENT SITUATION

BC remains committed to improving the health and wellness of First Nations people living in BC by supporting implementation of the *Transformative Change Accord: First Nations Health Plan* (2006), *Tripartite First Nations Health Plan* (2007), the *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (2011), and *Agreement in Lieu of Payment of the Medical Services Plan Premiums on behalf of First Nations People Resident in the Province of British Columbia* (2013), as well as other agreements.

### KEY FACTS

**Transformative Change Accord: First Nations Health Plan** and **Tripartite First Nations Health Plan**

- The *Transformative Change Accord: First Nations Health Plan* (TCA: FNHP), signed in 2006, and subsequent 2007 *Tripartite First Nations Health Plan* (TFNHP) were instrumental in laying the foundation to support improved health and wellness outcomes for and with BC First Nations, and developing a First Nations health governance structure.
- The TCA: FNHP and TFNHP supported the vision "…the health and well-being of First Nations is improved, the gaps in health between First Nations people and other British Columbians are closed, and First Nations are fully involved in decision-making regarding the health of their peoples."[1]
- Through 29 action items, priority areas fell under the following themes: governance, relationships, and accountability; health promotion/disease and injury prevention; health services; and performance measurement and tracking.[2]
- The original indicators of the TCA: FNHP have now evolved into the broader, wellness joint Population Health and Wellness Agenda, released on June 3, 2021.[3]

**BC Tripartite Framework Agreement on First Nation Health Governance (the Framework Agreement)**

- In 2011, the First Nations Health Council (FNHC), the Government of BC, and the Government of Canada signed the Framework Agreement, which laid the foundation for the creation of the First Nations Health Authority (FNHA).[4]
- In 2013, Health Canada transferred its role in the design, management, and delivery of First Nations health programming in BC to FNHA. Health programs and services include but are not limited to: select services in primary and public health, maternal/child health, mental health and substance use, environmental health monitoring, and non-insured health benefits.
- The health governance structure includes: FNHA, FNHC, the First Nations Health Directors Association, and the Tripartite Committee on First Nations Health. This partnership supports the alignment of leadership, health system planning and implementation, and service delivery.
- An evaluation of the Framework Agreement (covering the first five years since federal transfer to FNHA) was released in January 2020 at Gathering Wisdom, with recommendations actively being sought from BC First Nations leadership throughout 2021/22. This engagement has been delayed due to the impact of the COVID-19 pandemic).

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[1] First Nations Leadership Council, the Government of British Columbia, and the Government of Canada. (2017). *Tripartite First Nations Health Plan*. Retrieved from: https://www.health.gov.bc.ca/library/publications/year/2007/tripartite_plan.pdf.

[2] First Nations Leadership Council and the Government of British Columbia. (2006). *Transformative Change Accord: First Nations Health Plan*. Retrieved from: https://www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf.

[3] First Nations Health Authority and the Government of British Columbia. (2021). *Population Health and Wellness Agenda*. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/first-nations-population-health-wellness-agenda.pdf

[4] First Nations Health Council, the Government of British Columbia, and the Government of Canada. (2013). *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. Retrieved from: https://www.fnha.ca/Documents/framework-accord-cadre.pdf

**Agreement in Lieu of Medical Services Plan (MSP) Premiums on Behalf of First Nations People Resident in the Province of BC (MSP Agreement)**

- As part of transfer of services, Health Canada transferred to FNHA funding used to pay the MSP premiums on behalf of First Nations resident in BC. FNHA would then pay a portion of these fees to the Province and hold a portion to improve First Nations' access to primary care through the Joint FNHA-Ministry of Health Project Board (JPB).
- Extensions to the original 2013 Agreement have subsequently been adjusted to reflect the reduction and elimination of MSP premiums for all residents of BC.
- Although the Government of BC eliminated MSP premiums for all British Columbians effective January 1, 2020, FNHA still retains annualized funding to support JPB primary care projects.

**The Joint First Nations Health Authority – Ministry of Health Project Board**

- JPB was established in 2013 to support alignment of initiatives and services between the Province and the FNHA, while identifying and removing barriers to health service delivery and access.
- Annual funding of up to $15.33 million from the Ministry supports 27 projects in First Nations communities across BC to enhance service delivery and access in: mental health and substance use; primary care; maternal and child health; and oral health.
- Examples of approved projects include: multi-disciplinary teams with physician/nurse practitioner leads; Indigenous patient navigator; mobile mental health and crisis response units for children, youth, and adults; and a wrap-around chronic disease management and prevention team.

**Progress on BC's Key Commitments**

- The FNHA Chief Medical Officer (CMO) and the Office of the Provincial Health Officer (OPHO) have completed joint reporting on the progress of closing health gaps in seven indicators, including life expectancy, youth suicide rate, infant mortality rate, diabetes prevalence rate, childhood obesity rate, and age-standardized mortality. The 2018 final report[5] stated most targets were not met and acknowledged the importance of the heavy influence of other determinants of health.
- The CMO and OPHO have developed a new Population Health and Wellness Agenda, a suite of 22 wellness-focused indicators that better reflect on the determinants of health and were developed collaboratively through engagement with BC First Nations. It was released on June 3, 2021[6].
- The Ministry is works to embed cultural safety and Indigenous engagement in provincial primary care strategic initiatives.
- To foster the integration of health policy and services, the FNHA CEO is a member of the health system's Leadership Council, with other health authority CEOs and the Deputy Minister of Health; and FNHA has representation on all Standing Committees reporting to Leadership Council.
- An annual Letter of Mutual Accountability (LMA) is signed by the Ministry and FNHA to articulate key collaborative priorities, roles, and responsibilities of both parties, such as developing and implementing First Nations-led primary health care projects, ensuring First Nations perspectives are incorporated into workforce planning, advancing effective information and data-sharing, and collaborative emergency situation management. The partners have agreed to continue refining the approach to the 2021/22 LMA.

## FINANCIAL IMPLICATIONS

- The Ministry has provided $100 million during 2006/07 to 2019/20 to support the implementation of the Framework Agreement. In 2019/20, the Ministry provided a further lump sum of $22 million to further support the FNHA. In 2020/21, FNHA's base operating funding is approximately $18.9 million.
- The Ministry provided $5.51 million in 2016/17, $7.88 million in 2017/18, $10.27 million in 2018/19, $13.17 million in 2019/20 and $10.97 million in 2020/21 (up to Funding Letter Update #3) to support JPB primary care initiatives. The Ministry has an agreement with FNHA to fund these projects on an on-going basis.

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[5] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/indigenous-health-well-being-2018.pdf

[6] First Nations Health Authority and the Government of British Columbia. (2021). *Population Health and Wellness Agenda*. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/first-nations-population-health-wellness-agenda.pdf

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
February 8, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 14, 2021 – Breanna Chandler, ED, Office of Indigenous Health and Reconciliation
June 14, 2021 – Dawn Thomas, Associate DM, Indigenous Health

# LEGISLATIVE SESSION - FACT SHEET

## First Nations Social Determinants of Health - Mental Health and Wellness

### TOPIC

The Government of BC, including the Ministry of Health, has committed to advancing a social determinants of mental health and wellness approach with BC First Nations and the Government of Canada.

### CURRENT SITUATION

- In July 2018, the First Nations Health Council (FNHC), the Province of BC, and Canada signed the *Memorandum of Understanding (MoU) – Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness.*
- A tripartite senior executive forum (the Mental Health and Wellness Table) provides leadership, direction and key decision-making in the implementation of the investment and planning approach.
- The implementation of the MoU has been extended until March 31, 2022 through mutual agreement.

### KEY FACTS

- Health is impacted by factors beyond only illness, genetics, and behaviour: home conditions, education, employment, working conditions, culture, and community/social connections all contribute to health.
- Success in advancing the health and wellness of First Nations peoples in BC is grounded in strong governance, including:
    - The 2011 *British Columbia Tripartite Framework Agreement on First Nation Health Governance* demonstrates commitment to build an integrated health system that reflects First Nations traditional knowledge and approaches; and to engage in discussions about the social determinants of health;
    - The 2015 *Protocol on the Social Determinants of Health*, signed by the First Nations Leadership Council and the FNHC, confirms a shared commitment to improve health and wellness outcomes through engagement and cross-sector collaboration;
    - The 2016 bi-lateral *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 the provincial social ministries and First Nations leadership, culminating in a tripartite MoU; and
    - The 2018 tripartite *MoU – Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* confirmed provincial support through four Ministers' signatures: The Minister of Health, Mental Health and Addictions (MMHA), Children and Family Development (MCFD), and Indigenous Relations and Reconciliation (MIRR).
- The 2018 MoU supports Nation-rebuilding and health through a community-driven, Nation-based approach to the design, planning, and delivery of mental health/wellness services and supports. This is implemented through flexible funding to meet the needs and priorities of the Nation and its communities, with success measured by outcome indicators as determined by the Nation.
- Indigenous Services Canada (ISC), First Nations Health Authority (FNHA) and the Province of BC each committed $10 million over 2 years to support implementation of this MoU. In 2020/21, the FNHC requested extension of MoU implementation through March 31, 2022, and the Governments of BC (represented by the Ministry, MMHA, MCFD, and MIRR) and Canada agreed to this extension.
- The MoU implementation plan is supported by a tripartite governance structure, recognizing the different roles of the FNHC, FNHA, the Province, and Canada.
- Funding guidelines and supporting documentation, including FAQs, are publicly available for interested communities and Nations on FNHA's website[1].
- The Mental Health and Wellness Table (Co-Chaired by FNHA and MMHA) is actively reviewing Nation-based Statements of Readiness to access the funding. As of May 2021, the Table has received, reviewed, and/or

[1] https://www.fnha.ca/about/news-and-events/news/fnha-to-administer-new-$30-million-mental-health-and-wellness-fund; and http://www.fnha.ca/about/work-with-us/funding-opportunities

approved 51 Statements of Readiness that represent 166 unique First Nations communities (over three-quarters of the communities in the province). FNHA is administering the funding to Nations.

- The 2018 MoU also recognizes a need to build, repair, renovate, and expand a number of First Nations treatment centres across BC, funded separately from the $30 million commitment. In 2019, the Province and FNHA provided $10 million each, for a total of $20 million, to support First Nations treatment centres. This work continues to advance with FNHA as lead.
- The 2018 MOU also commits the tripartite partners to explore the development of a ten-year tripartite strategy that facilitates a whole-of-government approach for addressing the social determinants of health and wellness; the partners continue to explore opportunities to advance such as strategy.
- Through the First Nations health governance structure, continued engagement occurs with BC First Nations at regional caucus sessions and Gathering Wisdom. At Gathering Wisdom X in January 2020, FNHC launched its *Reclaiming Our Connections* guidebook and an engagement process to seek direction from BC First Nations leadership on its continued approach to the social determinants of health mandate, roles, and responsibilities over an 18-month period.
- The tripartite partners recognize some of the MoU progress expected by this point, principally, advancing development of a 10-year social determinants of health strategy, has not yet been achieved due to implementation delays and the COVID-19 pandemic.
- The extension of the MoU until March 31, 2022, will allow more time to advance key implementation activities. The partners are also interested in exploring the commitments in the MoU, particularly a long-term strategy that would sustain the flexible funding model established through the MoU. This interest also aligns with proposed actions, currently in the draft Declaration on the Rights of Indigenous Peoples Act Action Plan, which was released for public and partner engagement on June 11, 2021[2].

## FINANCIAL IMPLICATIONS

- The Province, through MIRR, provided $1.9 million over 2 years (2016/17 – 2017/18) in support of the engagement process to develop a shared 10-year social determinants strategy as per the 2016 MoU.
- The Ministry provided the FNHA $5.0 million in 2018/19 and 2019/20 to support the Tripartite Partnership to Improve Mental Health and Wellness. This funding represents the government's $10 million commitment to support planning and implementation of Nation-based plans and initiatives. The funding provided by the Ministry represents contributions from Health, MIRR, MCFD, and MMHA. The implementation of this funding has been extended until March 31, 2022.
- In 2019, the Province provided $20 million (matched by FNHA, for a total of $40 million) to build and revitalize First Nations treatment centres across the province.

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**Approved:**
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 14, 2021 – Breanna Chandler, ED, Office of Indigenous Health and Reconciliation
June 14, 2021 – Dawn Thomas, Associate DM, Indigenous Health

[2] https://engage.gov.bc.ca/govtogetherbc/consultation/declaration-act/

# LEGISLATIVE SESSION - FACT SHEET

# 'In Plain Sight' Report Recommendations Implementation

## TOPIC

- Dr. Mary Ellen Turpel-Lafond's independent report, *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in BC Health Care* (IPS), was released publicly on November 30, 2020.
- Included in the report are 24 recommendations for changes to address systemic indigenous-specific racism in the provincial health system.

## CURRENT SITUATION

- The Ministry of Health (MoH) and its multiple health system partners continue to advance the work needed to implement all 24 of the IPS recommendations.
- In January 2021, per Recommendation #13, Dawn Thomas was appointed to the newly created position of Associate Deputy Minister of Indigenous Health to lead the implementation of the recommendations in collaboration with Indigenous, health system, and provincial ministry partners.
- In alignment with Recommendation #24, a Task Team has been formed with Indigenous and non-Indigenous individuals 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.
- The Minister of Health issued a formal apology to Indigenous people the day the IPS report was released as per Recommendation #1. Other system partners have followed suit including, joint apologies on behalf of all Board Chairs and CEOs from regional health authorities and Provincial Health Services Authority (PHSA) on December 1, 2020. On May 11, 2021 formal apologies were 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 amendments to legislation are underway specific to IPS recommendations including:
    - Amendments to embed cultural safety and humility standards, definitions and expectations into the *Health Professions Act*. It will revise the complaints process to ensure these pathways are culturally safe. Engagement and Request For Legislation is expected to occur over the spring/summer.
    - Commencing development of an *Anti-Racism Act* under the leadership of the Parliamentary Secretary for Anti-Racism Initiatives.
    - Cross-government tables and processes being established to enact legislation to mandate the collection, use and disclosure of disaggregated demographic data.
- Joint presentations with the Ministries of Indigenous Relations and Reconciliation and Mental Health and Addictions to Regional Caucuses (note: Interior Caucus meetings postponed) on the IPS and the *Declaration Act* and how that will shape the path forward on meaningful engagement.
- Safe and supportive complaints processes have been identified as a priority for MoH and health authorities as per Recommendation #5. Collaborative working groups have been initiated to develop interim measures, supported by the Indigenous Health team at MoH.
- An IPS Partnership Table has been established with Métis Nation BC with it's first meeting occurring in May 2021 (Recommendation #7).
- A draft accreditation standard has been developed by a BC-led Indigenous Technical Committee, sponsored by the First Nations Health Authority in partnership with the Health Standards Organization. The draft standard is targeted for public review with Indigenous and non-Indigenous health system partners in late Spring 2021 (Recommendation #8).
- All health authorities now have at least 2 Indigenous Board members. There are also currently 3 Indigenous Vice Presidents (VP) as part of health authority senior executive teams (Northern, Island & Vancouver Coastal) with one VP position posted (Interior) and one VP position at Providence Health Care. (Recommendation #14).
- The MoH is exploring opportunities to:
    - advance on the commitment to review, assess and evaluate existing Cultural Safety & Humility programs at universities, colleges and institutes (Recommendation #18); and

  - work with the National Collaborating Center for Indigenous Health as a centre for anti-racism, cultural safety and trauma-informed standards, policy, tools and leading practices (Recommendation #19).
- Work has been initiated to review educational institutions' curriculum and to work with the Task Team on refreshing the approach to anti-racism, cultural humility and trauma-informed training (Recommendation # 20).

## KEY FACTS

- In June 2020, the Minister of Health appointed Dr. Mary Ellen Turpel-Lafond to lead 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]
- The review found and highlighted evidence of prejudice and racism throughout the BC healthcare system.
- In 2020, parallel to the independent review, the MoH actively worked to mobilize health system and cross-government partners for a coordinated provincial response. This short-term work was led by a former CEO of the Interior Health Authority and guided by an Advisory Committee of Indigenous Board members of health authorities, to focus on opportunities to affect meaningful change at the point of care.
- The *In Plain Sight* findings and recommendations align with the provincial response suggested actions, including the need to enhance recruitment and retention of Indigenous healthcare professionals, move cultural safety training upstream into medical school and the K-12 systems, coordinate with regulatory colleges and professional associations, and ensure strong governance, leadership, and accountability.
- The spirit and intent of the *Declaration on the Rights of Indigenous Peoples Act* requires the process for all legislative, policy and service changes impacting Indigenous peoples includes meaningful, purposeful engagement and collaboration through Indigenous Governing Bodies. The Ministry of Indigenous Relations and Reconciliation continues to work on guidelines for the implementation of the Act which will be applied throughout the engagement processes related to IPS implementation.
- Additional immediate steps that have been taken, in alignment with *IPS* and provincial response, include:
  - Five new Indigenous health liaison positions are being added in each regional health authority and PHSA, plus 2 additional positions at Providence Health Care, for a total of 32 new positions. These positions are being developed and implemented with Indigenous partners. As of the end of April 2021, 16 are filled and the rest are in the recruitment process.
  - Medical bylaws are under review by the MoH, and revisions will be implemented collaboratively, for consistent cultural safety and humility standards for medical staff privileges.
  - The BC Patient Safety and Quality Council held its inaugural engagement forum for Indigenous Board members in BC health authorities to come together for shared learning, visioning, and networking.
- 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.

## FINANCIAL IMPLICATIONS

- Budget 2021 provides $45 million over 3 years to help address systemic Indigenous racism in the health-care system.
- In partnership with the Task Team for In Plain Sight, MoH is reviewing how best to allocate the budget to support advancing the recommendations.

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**Approved:**
May 12, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
June 11, 2021 – Dawn Thomas, Associate DM, Indigenous Health

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

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Commitments to Reconciliation – Ministry of Health

### TOPIC

The Government of BC has committed to true and lasting reconciliation with Indigenous peoples, and the Ministry of Health has demonstrated significant action toward this commitment through established collaboration with key Indigenous partners.

### CURRENT SITUATION

The Government of BC has passed legislation to implement the United Nations Declaration on the Rights of Indigenous Peoples, which is confirmed by the Truth and Reconciliation Commission of Canada as a framework for moving toward true and lasting reconciliation.

### KEY FACTS

**Truth and Reconciliation Commission of Canada (TRC) Calls to Action**

- In 2015, the TRC published its final report detailing the experiences and impacts of the Indian Residential School system, creating a historical record of its legacy and consequences.
- The report resulted in 94 calls to action[1] across a range of areas including child welfare, education, health, justice, language and culture. The Ministry monitors 14 health-related calls to action.

**The Draft Principles that Guide the Province of BC's Relationship with Indigenous Peoples (Draft Principles)**

- In May 2018, the Province of BC released the Draft Principles, modeled on principles introduced by the federal government in 2017. The Province's principles provide high-level guidance to provincial representatives on how to engage with Indigenous peoples.
- They address areas such as: the right of Indigenous peoples to self-determination and self-government; the standard of conduct that government employees must demonstrate in all dealings with Indigenous peoples; and the need for recognition of inherent rights and respect.

**United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)**

- UNDRIP contains 46 articles that outline the individual and collective rights of Indigenous peoples regarding culture, identity, language, employment, health, education, and other issues. Several of these articles relate to the Ministry mandate, including those focused on the rights to self-determination and self-governance, respecting traditional medicines and health practices, and access to culturally safe and appropriate health and wellness services.
- In November 2019, the Government of BC enacted the *Declaration on the Rights of Indigenous Peoples Act Declaration Act* (*Declaration Act*). The purpose of the *Declaration Act* is to: a) affirm the application of UNDRIP to the laws of BC; b) contribute to UNDRIP implementation; and c) support the affirmation of, and develop relationships with, Indigenous governing bodies.[2] The legislation requires the Province to develop an action plan for implementation, in consultation and cooperation with Indigenous peoples, and table an annual report to monitor progress.
- A number of UNDRIP articles are relevant for the Ministry, such as those focused on the rights to self-determination and self-governance, respecting traditional medicines and health practices, and access to culturally safe and appropriate health and wellness services.
- The Ministry is well-positioned to support Indigenous health and wellness in BC, due to the establishment of the First Nations health governance structure and associated engagement and approval pathways, as well as key strategic partnerships with the Government of Canada, First Nations Health Council (FNHC), First Nations Health Authority (FNHA), BC Association of Aboriginal Friendship Centres, and Métis Nation BC (MNBC).
- A provincial approach is also being taken for engagement with MNBC and BCAAFC as led by the Ministry of Indigenous Relations and Reconciliation (MIRR).

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[1] Truth and Reconciliation Commission of Canada. (2015). *Calls to Action*. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

[2] *Declaration on the Rights of Indigenous Peoples Act, 2019*. Retrieved from: http://www.bclaws.ca/civix/document/id/complete/statreg/19044 .

- The Ministry recognizes that First Nations, Métis and Inuit populations are included in the *Declaration Act* and will continue to evolve partnerships to support all Indigenous peoples in BC.
- MIRR is coordinating development of the Provincial Action Plan, including ensuring respective ministry engagement with Indigenous communities and partners. The consultation draft Action Plan is now posted online for public engagement, June 11 through to July 31, with a target to release the Final Declaration Act Action Plan in the Fall of 2021.
- The Province released its first annual report on progress for implementing the *Declaration Act* on June 30, 2020[3], and it finalizing the second annual report for release at the end of June of this year.

**Ministry of Health Alignment with the Commitments to Reconciliation**

Ongoing work that supports the implementation of health related UNDRIP articles includes:

- The Minister of Health's 2020 commission of an independent review into allegations of racism in the B.C. emergency department setting, as well as the broader health system, and subsequent prioritization and action to implement the recommendations from *In Plain Sight*.
- Development of implementation plans for the Rural, Remote and Indigenous Framework, a collaborative framework which brings supports into rural, remote and First Nations communities during the COVID-19 pandemic and beyond. Implementation plans were developed in partnership with the ministry, FNHA, regional health authorities and through engagement with First Nations community leadership.
- Collaborative implementation of the *British Columbia Tripartite Framework Agreement on First Nations Health Governance* (2011);
- 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 provincial health system;
- Supporting community-driven, Nation-based initiatives to improve mental health and wellness through the *Memorandum of Understanding: Tripartite Partnership to Improve Mental Health and Wellness Services and Achieve Progress on the Determinants of Health and Wellness* (2018);
- Engaging Indigenous partners in health system planning and implementation processes, working to integrate First Nations team-based supports (e.g., Elders and traditional healers), and establishing First Nations Primary Health Care Initiative sites (e.g., Lu'ma Medical Centre);
- Partnering with the Office of the Provincial Health Officer, FNHA, and MNBC to enhance population health and wellness monitoring and reporting through the Population Health and Wellness Agenda and the Métis Public Health Surveillance Program;
- Working across the health system to ensure Indigenous priorities are embedded in policy and program development.

## FINANCIAL IMPLICATIONS

Financial implications regarding *Declaration Act* implementation have not yet been identified.

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**Approved by:**

June 14, 2021– Breanna Chandler, Executive Director, Office of Indigenous Health
June 14, 2021 – Dawn Thomas, Associate DM, Indigenous Health

[3] https://news.gov.bc.ca/releases/2020IRR0012-001198

# LEGISLATIVE SESSION - FACT SHEET

# Tk'emlúps te Secwépemc

## TOPIC

On May 27, 2021, Tk'emlúps te Secwépemc announced the confirmation of the remains of 215 children, who had been students of the Kamloops Indian Residential School, on the residential school grounds[1].

## CURRENT SITUATION

Background

- Tk'emlúps te Secwépemc ("TteS") worked with a ground-penetrating radar specialist to survey the residential school grounds. Preliminary ground survey work occurred in the 2000s. With new technology, TteS has been able to now share this quantitative 'finding,' which serves to validate community knowledge of atrocities, including death, that were inflicted on children at this residential school.
- This is a highly sensitive and distressing for many, but especially for Indigenous peoples, who experience personal, family, and community impact of the residential school system and ongoing colonialism.

Key Messaging

- Tk'emlúps te Secwépemc (pronunciation: *tuh-kum-loops teh suh-wep-moohk*) [2] has provided tremendous leadership in demonstrating this difficult truth to other British Columbians, government, and partners.
- The Province of BC stands with Tk'emlúps te Secwépemc in support of their truth and leadership.
- We grieve the incomprehensible loss of 215 children, who should have all been able to lead full lives, experience joy, grow and flourish. These children did not have the opportunity to become parents, grandparents, Elders, knowledge keepers, and leaders, and this creates a deep void for communities.
- The residential school system created devastating impacts for Indigenous peoples, families, and communities. The Ministry of Health accepts its role in acknowledging truths and enacting meaningful, continuous acts of reconciliation, to repair generations of violence and ongoing impacts of colonialism.

Action and Collaboration

- The Office of the Premier and the Ministry of Indigenous Relations and Reconciliation (MIRR) have been fielding high-volume requests, engaging in dialogue, and leading appropriate, initial provincial response.
    - On May 28, 2021 the Premier[3] and Chief Coroner[4] have issued statements acknowledging this devastating revelation, and committing to further collaboration with TteS.
- The First Nations Health Governance Interior Regional Caucus, scheduled for June 2-4, 2021 was postponed to allow the region to have time to gather in ceremony, mourn, and heal.
    - The First Nations Health Council have advised the Province of BC (through its health partnership) to not enact 'grand gestures' from government right now; rather, partners need time to gather and grieve.
- Interior communities are leading ceremonies, including a 4-day sacred fire burned by TteS and a "Walking our Spirits Home" event hosted by Adams Lake Indian Band, scheduled for June 11-13, 2021.
- Local and regional work also continues. This includes:
    - MIRR is providing direct support to the community and Nation in their ongoing daily needs, including coordinating on-site logistical demands. As of May 31, 2021, TteS has respectfully directed protocol that external parties (i.e., media) should defer any visits to the community at this time.[5]
    - Interior Health Authority (IH) team have also been actively engaged in identifying community needs, through collaboration with the First Nations Health Authority (FNHA). At this time, needs that have been identified focus on supporting safe community gathering (e.g., PPE, supplies, event management

[1] TteS media release: https://tkemlups.ca/wp-content/uploads/05-May-27-2021-TteS-MEDIA-RELEASE.pdf
[2] Thompson River University Secwépemc Communities Pronunciations (audio file): https://www.tru.ca/indigenous/indigenous-education-team/pronunciations.html
[3] Premier's news release: https://news.gov.bc.ca/releases/2021PREM0039-001034
[4] Chief Coroner's news release: https://news.gov.bc.ca/releases/2021PSSG0046-001039
[5] TteS media release: https://tkemlups.ca/wp-content/uploads/05-May-31-2021-TteS-MEDIA-RELEASE.pdf

support). IH will continue to work with FNHA and community leadership to appropriately respond and support, potentially including redeploying resources, as needed in the future.
    - FNHA and the Indian Residential School Society provide mental health counselling to residential school survivors and Indigenous peoples impacted by intergenerational trauma. Other partners (e.g., Métis Nation BC) also provide mental health crisis supports for Indigenous peoples.
    - FNHA is also accelerating COVID-19 immunization clinics for second dose vaccine roll-out for TteS.
- IH and FNHA have noted this revelation is extremely impactful for staff, who work at or near the Kamloops Indian Residential School site, support community members, and may be experiencing vicarious trauma. The Ministry of Mental Health and Addictions will be developing and sharing psychosocial resources that are available to support front-line health system staff. There may also be the opportunity to consider health system redeployment in the future (e.g., from the Provincial Health Services Authority).
- Appropriate truth-telling actions and mental health supports will be important, and dovetail with The Truth and Reconciliation Commission of Canada (TRC) Calls to Action, Calls to Justice from the National Inquiry into Missing and Murdered Indigenous Women and Girls, and recommendations *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in BC Health Care*.

## KEY FACTS

- TteS is a community that is part of Secwépemc Nation in the Interior of BC. TteS was the home community of the Kamloops Indian Residential School, and as such, "acknowledges their responsibility to caretake for these lost children"[6] (recognizing many of the children's home communities may be elsewhere).
- Kamloops Indian Residential School was opened under Roman Catholic administration in 1890; it became the largest school in the Indian residential school system. In 1969, the federal government took over administration, operating as a residence for local day schools until 1978, when the residence closed.[7]
- The TRC operated from 2008 to 2015, as mandated by the *Indian Residential Schools Settlement Agreement*. The TRC Final Report described 6 Calls to Action[8] specific to missing children and burial information, which included work for federal and provincial governments, churches, chief coroners, provincial vital statistics, communities, and other partners to work on ongoing identification of missing children, documentation, maintenance, commemoration, ceremony, and protection of residential school cemeteries.

## FINANCIAL IMPLICATIONS

None determined at this time

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**Approved:**
June 14, 2021 – Breanna Chandler, ED, Office of Indigenous Health and Reconciliation
June 14, 2021 - Dawn Thomas, Associate DM, Office of Indigenous Health and Reconciliation

[6] TteS media release: https://tkemlups.ca/wp-content/uploads/05-May-27-2021-TteS-MEDIA-RELEASE.pdf
[7] Indian Residential School History & Dialogue Centre: https://collections.irshdc.ubc.ca/index.php/Detail/entities/46
[8] TRC Calls to Action: http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

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# LEGISLATIVE SESSION - FACT SHEET

## Chronic Disease Management

### TOPIC

Chronic disease is the largest cause of death and disability, represents the largest proportion of the burden of disease, and drives significant downstream health costs in BC.[1] There are a range of supports available to help patients and health care providers manage chronic diseases.

### CURRENT SITUATION

System Level Supports

- The *Healthy Families BC Policy Framework: A Focused Approach to Chronic Disease and Injury Prevention*, released in 2014, sets out the framework for chronic disease prevention in BC.[2]
- The Lifetime Prevention Schedule, developed in partnership with Child Health BC and Doctors of BC (DoBC), establishes priorities for effective clinical prevention services that are based on clinical effectiveness, population health impact, and cost effectiveness. These include screening, behavioral interventions, and preventative medications.
- The Ministry of Health's Patients as Partners Initiative has dedicated funding to build the capacity and capability of patients, families, caregivers, and health care providers to manage chronic diseases. Health care providers, patients and families, including Indigenous organizations and Elders, and multi-cultural communities, are often consulted when creating and/or adapting, and/or providing services and resources, to ensure they are culturally appropriate and in some cases, translated. Services are contracted through the University of Victoria's (UVIC) Self-Management BC program, the University of BC's (UBC) intercultural Online Network, the Centre for Collaboration, Motivation and Innovation (CCMI), Family Caregivers of BC (FCBC), and Pain BC.

Support for Providers

- BC Guidelines are clinical practice guidelines and protocols developed by the Guidelines and Protocol Advisory Committee (GPAC) and targeted toward primary care providers. GPAC has developed several BC Guidelines providing evidence-based guidance related to chronic disease management, including Chronic Heart Failure, Chronic Kidney Disease (CKD), Chronic Obstructive Pulmonary Disease (COPD), Diabetes Care, Hypertension, Asthma, Major Depressive Disorder, Opioid Use Disorder, and several Cancer guidelines. GPAC is also developing a new guideline on Managing Pain.
- The General Practice Services Committee (GPSC) is a joint committee of the Ministry of Health and the DoBC. GPSC has introduced a range of chronic disease management incentives over the past ten years to influence chronic disease patient registry development, planned proactive chronic disease management, and to better support family physicians to develop care plans for patients with chronic illnesses. In 2019/20, these incentives were billed by 3,852 physicians to support 612,464 patients.[3]

Support for Patients

- The Ministry's Patients as Partners Initiative has dedicated funding to build the capacity and capability of patients, families, and caregivers to manage chronic diseases. Services are contracted through UVIC's Self-Management BC program, the UBC's intercultural Online Network, the CCMI, FCBC, and Pain BC. Between April 2019 and March 2020, more than 21,000 patients, families, caregivers, health-care providers, and health administrators were reached through events and services, and resources were distributed to more than 567,591 people.[4]
- Home Health Monitoring (HHM) uses connected technology and clinical protocols to monitor individuals living in their homes with chronic conditions. The Province has allocated funding through the Strategic Investment Fund to develop HHM protocols and services.[5]
- Health authorities and specialists offer clinics and services to support patients with more rare or complex

[1] Ministry of Health (MOH) 2018/19 – 2020/21 Service Plan Retrieved March 2, 2018: http://bcbudget.gov.bc.ca/2018/sp/pdf/ministry/hlth.pdf
[2] MOH. 2014. Healthy Families BC Policy Framework. https://www.health.gov.bc.ca/library/publications/year/2014/healthy-families-bc-policy- framework.pdf
[3] MOH, HSIAR, Medical Services Plan database, extracted February 3, 2021.
[4] Patients as Partners Collective Impact Summary 2019-20 final draft report.
[5] MOH, Hospital, Diagnostic and Clinical Services Division, Home Health Monitoring Fact Sheet 2018

chronic conditions. One example of this is the Complex Chronic Diseases Program at BC Children's and Women's Hospital that provides care for patients with Chronic Lyme-Like Syndrome, Fibromyalgia, Myalgic Encephalomyelitis/Chronic Fatigue Syndrome, and Multiple Chemical Sensitivities.

## KEY FACTS

- Chronic disease is the largest contributor to total health care costs in BC.[6] British Columbians living with one or more chronic conditions consume approximately 80% of the combined Medical Services Plan, PharmaCare, and acute care budgets.[7]
- Chronic diseases are long-term conditions that usually progress slowly over time. They include common conditions like Heart Disease, Diabetes, CKD, Asthma and COPD, Depression, and Arthritis, among others.[8]
- One in three British Columbians is living with one or more diagnosed chronic conditions, and 2% of the population is living with four to six chronic conditions. A further 17% of British Columbians may be living with at least one undiagnosed chronic condition.[9]
- The prevention and management of chronic diseases includes a continuum of care ranging from prevention, screening and assessment, to self-care, management, and treatment.
- To prevent the onset of chronic disease, prevention focuses on addressing common risk factors, such as tobacco use, physical inactivity, unhealthy eating, and risky alcohol use.
- Chronic disease management is the ongoing care and support to assist individuals in managing a chronic health condition, and includes medical care, knowledge, skills, and resources to better manage on a day to day basis. It incorporates self-management, and support from family physicians/primary health care providers, community-based programs, and specialist programs and services.

## FINANCIAL IMPLICATIONS

- The Ministry made the following funding available for chronic disease self-management support through the Patients as Partners Initiative in 2019/20 and 2020/21:
  - Pain BC: Up to $0.750 million.
  - UVIC Self-Management: Up to $2.484 million.
  - UBC InterCultural Online Health Network: Up to $0.785 million.
  - CCMI: Up to $0.750 million.
  - FCBC: Up to $0.500 million.
  - Richard Delaney & Associates: Up to $0.450 million.
- In response to the COVID-19 pandemic, the Province announced an additional $0.500 million in 2020/21 for FCBC to provide further supports to family caregivers.[10]
- The Strategic Investment Fund has allocated $40 million to the HHM initiative and $39.16 million was spent at the end of the 2020/21 fiscal year.[1111]

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**Approved:**
February 1, 2021 - Shana Ooms obo Ted Patterson, ADM, Primary Care Division
February 8, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 23, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
April 14, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

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[6] BC Office of the Provincial Health Officer. Investing in Prevention: Improving Health and Creating Sustainability. August 2010.
[7] MOH. March 2017. Promote, Protect, Prevent: Our Health Begins Here, BCs Guiding Framework for Public Health, p. 6. https://www.health.gov.bc.ca/library/publications/year/2017/BC-guiding-framework-for-public-health-2017-update.pdf
[8] Interior Health Authority, Chronic Disease Management https://www.interiorhealth.ca/YourCare/ChronicConditionDisease/Pages/default.aspx
[9] Ibid. Promote, Protect, Prevent. p. 6.
[10] MOH News Release. April 26, 2020. More support for family caregivers during COVID-19. https://news.gov.bc.ca/releases/2020HLTH0141-000763
[11] Email communication, Paul Payne (Patient Empowerment Portfolio Lead, Digital Health Initiative, MOH), September 18, 2020 & April 7, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Community Health Centres

### TOPIC

- In 2018/19 the Ministry of Health launched a transformational team-based primary care strategy, envisioned to increase patient attachment, and access to quality, comprehensive, culturally safe and person-centred primary care services across the province. Team-based primary care will be delivered using a number of different models including Community Health Centres (CHCs).
- The Ministry's policy direction states that CHCs are multi-sector organizations providing a community population with primary health care. The community population served by CHCs is typically geographically defined, although a CHC may target their services to a community of specialized need residing across multiple geographic areas. CHCs are community governed and/or community informed with services tailored to meet the health needs of the community.
- CHCs also prioritize the attachment of hard-to-reach, vulnerable, and under-served populations, and are a key resource in helping to address social determinants of health through linkages to other community agencies.
- As part of the NDP 2017 election campaign, four commitments were made by the NDP government to the BC Association of Community Health Centres (BCACHC): Allocating up to $6 million to support existing CHCs in 2017/18; establishing a partnership table with BCACHC and stakeholders; commencing with annualized funding for existing CHCs by 2018/19; and seek to expand the CHC model by 2020.[1]

### CURRENT SITUATION

- The 2020/21 Regional Health Authority Bi-Lateral Agreements state that regional health authorities support, as requested by the Ministry, the development of new or significantly refreshed and expanded community health centres by the end of 2020/21.
- As part of the primary care strategy, three CHCs are in operations: 'RISE' in Renfrew Collingwood (Vancouver Coastal Health Authority); Island Sexual Health Society (Vancouver Island Health Authority) and Umbrella Multicultural Health Cooperative (Fraser Health Authority).
- Two additional CHCs are in late planning: Westshore CHC (Vancouver Island Health Authority) and Lake Country (Interior Health Authority). CHCs in early planning are: Bowen Island Health Centre Foundation (Vancouver Coastal Health Authority) and Luther Court Society (Vancouver Island Health Authority).
- In 2019, the Ministry completed an evidence and partner informed supportive policy direction outlining the expected CHC service model in BC.[2]
- The Ministry, in partnership with McMaster University, has completed research to contribute to evidence-based approaches to the CHC clinical model policy development that will further inform planning for enhanced and net new CHCs.
- In 2020, in their collaboration with BCACHC, the Ministry established a cross-government, cross sectoral, provincial Partnership Table, of which the first of quarterly meetings convened in November 2020. As follow up, smaller subgroup meetings will convene and are slated for May 2021.

### KEY FACTS

- CHCs have delivered community primary care, health promotion, and social services in BC for over 50 years.
- According to the Canadian Association of CHCs, a CHC is any not-for-profit corporation or cooperative which adheres to the following five domains: 1) Inter-professional primary care 2) Services/programs in primary care, health promotion, and community well-being 3) Community-centred 4) Addresses the social determinants of health 5) Demonstrates commitment to health equity and social justice.
- In BC, CHCs provide varying degrees of primary care services and enable patient access to an inter-disciplinary team of health care professionals (e.g. Family Practitioners, Nurse Practitioners, Licensed Practical Nurses, Social Workers, Allied Health Therapists, Support Workers, Community Health Workers, Dentists, etc.). CHCs enable better access to social sector supports and agencies in the community to address the broader social

[1] BC New Democratic Party, Letter to Grey Showler President-British Columbia Association of Community Health Centres. April 2017.
[2] Supportive Policy Directive: Community Health Centres (2019).

determinants of health, such as access to interpreters for newcomers, health promotion programs, and food security, among others.

- Health authorities own and operate clinical models sometimes referred to as CHCs; however, these are not the same as a community-governed, not-for-profit CHC. According to BCACHC, there are approximately 28 community- governed CHCs in BC.[3]
- With the recent addition of CHCs under the primary care strategy, CHCs are a flexible and person-centred, adaptive model, aligned to specific communities, and reflective of local primary health care need.
- Currently, community governed CHCs do not receive core operational funding from the Ministry, though many do receive funds through sustainment or emergency funding from the Ministry via the BCACHC. Other service arrangements may be supported by health authorities or funded through Fee-for-Service, while others may receive ongoing funding from other provincial ministries (e.g. BC Housing) for their services. Many existing CHCs were built and paid for by local community members who still finance major portions of the health and social services delivered.
- Due to the social inequities and disparities in health outcomes experienced by Indigenous populations, prioritization for CHC expansion may support enhancing and developing First Nation-governed CHCs, and are an appropriate model to leverage for First Nation-Led Primary Care Clinics.
- 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 also may also include: Clinical Pharmacists, Traditional Healers, Elders, and Mental Health and Substance Use Workers.
- Existing CHCs and community groups that are interested in forming a partnership, and either significantly enhancing or building a net new CHC, are encouraged to reach out to their health authorities and work with local Primary Care Network (PCN) steering committees wherever possible, as the CHC clinical service model will be integrated into overall PCN service provision.[4]

**FINANCIAL IMPLICATIONS**

- In 2020/21 the Ministry provided the following funding:
  - $0.928 million to Umbrella Multicultural Health Cooperative CHC via Fraser Health Authority.
  - $1 million to the Mid-Main CHC to support the expansion and relocation in March 2021.
  - $2.13 million to BCACHC to promote the CHC vision of health and well-being in March 2021.
- In 2019/20 the Ministry provided the following funding:
  - $859,183 to Collingwood Neighbourhood House Society via shared cost arrangement.
  - $1 million to BCACHC in March 2020 for requests for future planning and sustainment of CHCs. 'STEPs' in Kamloops was the first recipient of the BCACHC grant, receiving $100,000.
  - $100,000 to Sun Peaks Health Association in March 2020.
  - $1 million to Bowen Island Health Centre Foundation in March 2020.
  - $262,650 to Island Sexual Health Society (the Ministry provided $160,000 and the Vancouver Island Health Authority provided $102,650).
  - $156,000 to Umbrella Multicultural Health Cooperative via Fraser Health Authority.
  - $384,000 to Mid-Main CHC via Vancouver Coastal Health Authority.
- In 2018/19 the Ministry provided funding of $111,000 to Collingwood Neighbourhood House Society via shared cost arrangement.
- In 2017/18 the Ministry provided funding of $2.13 million to the BCACHC to help address immediate clinical service gaps experienced by 14 CHCs.

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**Approved:**
February 1, 2021 - Shana Ooms obo Ted Patterson, ADM Primary Care Division
February 7, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[3] BC Association of Community Health Centres website: http://www.bcachc.org/ourmembers/ Accessed January 15, 2021.
[4] See Primary Care Network Fact Sheet for more information.

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Primary Care Response

## TOPIC

- In 2018/19, the Ministry of Health launched a transformational team-based primary care strategy envisioned to increase patient attachment and access to quality, comprehensive, culturally safe, and person-centred primary care services across the province. Team-based primary care will be delivered using a number of different models including:
  - Full-service Family Practices/Patient Medical Homes (PMHs)
  - Urgent and Primary Care Centres (UPCCs)
  - Community Health Centres (CHCs)
  - First Nations Primary Care Clinics (FNPCCs)
  - Nurse Practitioner (NP) Primary Care Clinics (NPPCCs)
- These clinical models, linked to Primary Care Networks (PCNs), enabled the Ministry to quickly mobilize, stand up and redirect primary care services in support of Ministry and partners' response to the COVID-19 pandemic.

## CURRENT SITUATION

- The Ministry and health care partners continue to work together to support providers, patients, and their caregivers during the COVID-19 pandemic.
- New initiatives and guidance have been established and continue to operate across the primary care system to help control the spread of the virus, keep patients out of acute care settings, and to provide high quality primary and community care.

## KEY FACTS

- The Ministry and its partners have taken proactive steps to build health care system capacity, to ensure health care providers have the tools and guidance to safely and effectively deliver primary care under different pandemic scenarios, and are well positioned to continue supporting COVID - 19 testing/treatment in community.
- On September 9, 2020, the Ministry published *the Management of COVID-19: Health Sector Plan for Fall/Winter 2020/21*)[1] to address COVID-19, a plan consisting of 24 Ministry-led Priority Action Areas. From October 2020 through early January 2021, the Ministry completed the following:
  - Action #6: Primary Care Readiness for Routine and COVID Care Delivery
  - Action #7: Primary Care Guidelines and Pathways for COVID Patients
  - Action #8: Keep Those with Chronic Disease or Serious Illness Well at Home
  - Action #9: Preparation for Acute Respiratory Care Centres
- In conjunction with the *COVID-19: Health Sector Plan,* in September 2020, the Ministry released the COVID-19 Fall Response Framework to coordinate all regional health authorities in their primary care pandemic response. An urgent approval process for implementation received over 50 applications for primary care initiatives.

**Enhancing Routine and COVID Care Delivery**

- In November 2020, the Ministry launched a new centralized Personal Protective Equipment (PPE) 'portal' distribution service that provides general practitioners, NPs, and specialists in community clinics with access to free PPE.
- Health authorities, Divisions of Family Practice, and First Nations partners in primary care have developed strategies and processes for screening, assessing, and testing for COVID-19 in primary care settings, including establishing Acute Respiratory Care Centres alongside specific UPCCs, and consolidated, primary care clinics to meet the assessment, testing, and short-term 14-day care needs of COVID-19 patients. Innovative approaches such as drive-through testing sites and testing for vulnerable populations (e.g. virtual/in-person testing through homeless shelters) have also been used. The Ministry also provided funding for Influenza clinics to proactively decrease the burden on healthcare facilities.

[1] https://news.gov.bc.ca/files/COVID-19_fall-winter_preparation.pdf

- Together with the First Nations Health Authority, Northern Health Authority (NHA) and the Ministry, in response to the COVID-19 pandemic, the Ministry provided urgent funding to the Real-Time Virtual Support (RTVS) program for rural and Indigenous populations to increase access to virtually enabled care. Key initiatives include HealthLink BC Emergency iDoctor-in-assistance program (HEiDi), First Nations Virtual Doctor of the Day (FNvDOD), First Nations Virtual Substance Use and Psychiatry Services (FNvSUPs), the Rural Urgent Doctors in-aid program (RUDi), Rural Outreach Support program (ROSe), Child Health Advice in Real-Time Electronically program (CHARLiE), and Maternity and Babies Advice Line (MaBAL)[2]. These services continue to be supported in fiscal 2021/22. Since April 2020, HEiDi has provided over 30,000 patient consults and triaged 74% of callers from requiring emergency care and FNvDoD has supported over 6,000 client encounters, while FNvSUPs has supported over 1,100 client encounters[3].
- Over 3 million British Columbians received virtual primary care in the April-December 2020 period[4].
- Medical fee-for-service expenditures for virtual care during this period increased significantly in response to COVID-19. In January and February 2020 virtual care made up 2% of fee-for-service (FFS) expenditures. This increased to 15% in March and a high of 40% in April 2020. Virtual care remained above 25% of FFS for the rest of 2020 and represented 29% of FFS billing in December 2020.

**Clinical Care Guidelines**

- Health authorities, primary care providers, and specialists are working together to identify, prioritize, and take action to keep older patients and those with serious medical conditions healthy at home. The Ministry, with the Provincial Health Services Authority(PHSA), developed a guidance tool for primary care providers on the assessment and outpatient management of adult patients with symptoms suggestive, suspected, or confirmed COVID-19.
- PHSA, supported by the Ministry and clinical reference groups, developed a guidance tool on older patients and individuals more likely to experience a serious form of illness due to underlying chronic medical conditions (e.g., cardiac patients, transplant patients). The guidance tool, *BC Care Bundle for Supporting High-Risk Patients During COVID-19 Pandemic and Influenza Season*, provides recommendations for all care providers managing high-risk patients during the COVID-19 pandemic and influenza season. Current work also includes the development of long hauler guidance for physicians to support their patients who are experiencing symptoms months after contracting COVID-19.

**Compensation and Incentives**

- To increase virtual access, telehealth fee codes have been adjusted. Physicians can temporarily bill Medical Services Plan for telehealth. Use of a related in-person fee code is also available.
- To support the operationalization of the *BC Care Bundle*, Ministry made available one-time funding for physicians along with incentive funding for physicians to participate in pandemic response planning.
- Short-term simplified service contracts were put in place to compensate physicians in consolidated clinics, where fee-for-service was not viable due to safety protocols, number of patients per hour and new fee codes were implemented for COVID-19 visits, and respiratory immunization.
- The Ministry, via the Joint Collaborative Committees, has implemented grants of up to $1,000 for physicians who have incurred costs implementing a provincially aligned COVID-19 Safety plan.

## FINANCIAL IMPLICATIONS

Combatting COVID-19 has necessitated significant investments in primary care. In 2020/21, in response to the COVID-19 Fall Response Framework, health authorities reported approximately $9.1 million in incremental costs related to primary care. .

**Approved:**

May 12, 2021 - Shana Ooms obo Ted Patterson, ADM Primary Care Division

May 14, 2021 – Kerri Harrison, obo Philip Twyford, ADM, Finance and Corporate Services Division

[2] Health Advice in Real-Time Electronically program (CHARLiE), and Maternity and Babies Advice Line (MaBAL).

[3] Integrated Analytics: Primary Care, Acute Care and Workforce. Insights from Analytics: Physician Provision Pre & Post COVID-19. October 2020.

[4] HSMIT Fact Sheet, accessed by HSIAR, Jan 2021. Includes all providers.

# LEGISLATIVE SESSION - FACT SHEET

## General Practice Services Committee

### TOPIC

The General Practice Services Committee (GPSC) is a partnership between the Doctors of BC and the Ministry of Health to:

- Increase access to appropriate, comprehensive, quality primary health care in the community;
- Improve support for patients, including vulnerable patients, through enhanced and simplified linkages between providers (Family Physicians (FPs), specialists and allied health providers), and health authority and other community services;
- Contribute to building a more effective, efficient, and sustainable health care system in order to increase capacity and meet future patient needs; and,
- Retain and attract FPs and teams to work together in healthy and vibrant work environments.

### CURRENT SITUATION

- Since March 2020, a key focus for the GPSC has been to enable a coordinated primary care and community response to the COVID-19 pandemic. The GPSC pivoted quickly to respond to the needs of FPs and provincial partners. To support practices and providers shifting to virtual care, the GPSC billing codes were adapted to support virtual care, and the business cost premium was expanded. The Doctors Technology Office released virtual care guides and held webinars to provide online training for physicians. Through the Practice Support Program, targeted practice coaching and tools helped practices define and reach out to vulnerable populations. Physician participation in community planning continues to be supported by relaxed funding parameters, which allow divisions to use existing GPSC funds to prioritize resources towards responding to the current pandemic.
- During the second phase of the pandemic, a key focus was to enable a coordinated primary care and community response. Key areas of work included supports for divisions to implement COVID-19 action plans, in accordance with the Ministry of Health Fall/Winter Primary Care COVID-19 Response Framework, and working collaboratively with health authorities to develop Personal Protective Equipment (PPE) supply calculations for community practices. With strong influence from the GPSC, community FPs have been included in the provincial PPE supply chain.
- As of February 2021, 71% (2,789) of Majority Source of Care FPs in BC have completed the patient medical home assessment at least once since it was introduced in Summer 2017. (source: GPSC COMET database)
- As of February 2021, over 2,335 physicians have received or been approved for the panel management payment for committing to the phases of panel management, and 1,467 of which have completed all 3 phases. (source: GPSC COMET database)
- The GPSC Patient Experience tool has over 7,511 surveys completed by patients since it was introduced in Spring 2017 (source: GPSC Patient Experience database).

### KEY FACTS

**Enabling Structures**

Divisions of Family Practice – Divisions were developed in response to FPs' concerns of feeling isolated and lacking a voice in the health system. Divisions are community-based groups of FPs working together to achieve common health care goals, address primary care gaps, and promote health system integration. There are currently 35 Divisions in BC that encompass 230 communities.[1] Through Collaborative Services Committee (CSC) tables, Divisions' representatives partner with health authority representatives to collaborate and discuss ways of working together more effectively, to improve the health of populations and services in their communities. Each CSC may also have representation from local community agencies as well as from the GPSC, local First Nations, and patients.

[1] https://www.divisionsbc.ca/provincial/home Retrieved February 27, 2019

Patient Medical Homes (PMHs) and Primary Care Networks (PCNs) – The GPSC is the leading collaborative table for primary health care transformation in BC. It supports the implementation of PCNs enabled by team-based care, and development of PMHs as the foundation for care delivery and cornerstone of PCNs.

**Enabling Incentive Fees, Initiatives, and Quality Improvement Supports**

Incentive Program - In September 2018, the GPSC introduced the Panel Development Incentive to compensate FPs and their practice teams for the time and effort to identify their active patients, develop patient registries, and establish new processes for providing planned proactive care to respond to patients' chronic and preventative care needs. The incentive is $6,000 per eligible FP and can be claimed once per eligible FP.[2]

Community Longitudinal Family Physician (CLFP) Payment - In December 2019, the GPSC introduced the CLFP Payment to compensate community-based FPs who work under fee-for-service, and who care for a panel of patients for providing long-term, relationship-based care. The first CLFP Payment was paid to eligible FPs in January 2020. Eligible FPs received a total payment amount of no less than $3,000, and up to $12,000, with exact payment amount per individual physician based on the number and complexity of Majority Source of Care patients associated with the physician in the Medical Services Plan database.[3]

GPSC Incentive Fees - Per the 2019 Physician Master Agreement, all GPSC incentive fees, except In-Patient Network (G14086, G14088) and Maternity Network (G14010), will be transferring from the GPSC to the Available Amount on April 1, 2020. In 2019/20, there were 5,422 unique FPs who provided GPSC incentive-based care (# of FPs who billed a GPSC fee at least once) to 1,296,079 distinct patients in BC.(source: GPSC COMET database) Incentives (e.g. payments and fees) include Maternity Care, Chronic Disease Management, Palliative Care, Complex Care Fee, FP Advice to Nurse Practitioner or Registered Midwife Fee, Conference and Telephone Management, Community Based Mental, and In-Patient Care Fee.

Long-term Care Initiative – GPSC has made available $12 million in annual funding for the provincial Long-term Care Initiative, to help ensure that patients living in long-term care facilities have an FP.[4]

Practice Support Program – This is a quality improvement-focused initiative that supports doctors and practice teams to practice more efficiently, focus on providing proactive care, and work towards adopting attributes of the PMH. The Practice Support Program offers clinical and practice management learning opportunities, and data- informed tools and resources —both supported by a team of practice improvement professionals, including physician and Medical Office Assistant peer mentors.

## FINANCIAL IMPLICATIONS

Per the Physician Master Agreement, for 2020/21 the GPSC annual funding is $326 million.[5]

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**Approved:**
February 12, 2021 - Shana Ooms obo Ted Patterson, ADM Primary Care Division
February 17, 2021 - Eric Larson obo Martin Wright, ADM Health Sector Information, Analysis and Reporting Division
April 7, 2021 - Philip Twyford, ADM, Finance and Corporate Services Division

[2] https://gpscbc.ca/what-we-do/incentives/panel-development-incentive
[3] https://gpscbc.ca/news/news/new-payment-support-longitudinal-care
[4] GPSC Workplan, 2.3 Clinical Payments and In-Practice Tools
[5] 2019 General Practitioners Subsidiary Agreement, Articles 5.1, 5.3, 5.7 & 5.8

# LEGISLATIVE SESSION - FACT SHEET
# Guidelines and Protocols Advisory Committee

## TOPIC

The Guidelines and Protocols Advisory Committee (GPAC), a collaboration between the Doctors of BC (DoBC) and the Ministry of Health, is established under Section 5(1)(o) of the *Medicare Protection Act* as an advisory committee to the Medical Services Commission (MSC).[1]

## CURRENT SITUATION

- GPAC is mandated to provide recommendations to primary care practitioners in BC, with the overall goal of supporting quality medical care while making optimal use of medical resources.
- Winter and Spring 2020/2021 guideline updates include:
  - **Revised/Under Revision:** Cardiovascular Disease, Cataracts, High Ferritin and Iron Overload, Obstructive Sleep Apnea, Diabetes Care, Osteoporosis.
  - **New/Under Development:** CT and MRI Prioritization, Fall Risk Assessment, Managing Pain, Adverse Childhood Experiences (ACEs) and Trauma-Informed Practice.

## KEY FACTS

The MSC provides direction to GPAC in matters related to the provision of guidelines and protocols for medical services in BC. Joint responsibility for developing guidelines and protocols is mandated in the *2019 Physician Master Agreement* to the Ministry and the DoBC.[2]

<u>BC Guidelines Overview</u>

- GPAC produces short, user-friendly, clinical practice guidelines with a focus on primary care.
- Over the past 20 years, GPAC has established a reputation among the BC medical community as a creator of high-quality, reliable, and evidence-based clinical practice guidelines.
- GPAC has well-established processes for developing guidelines and has participated in many successful collaborations with BC stakeholders, e.g. the BC Centre on Substance Use and the BC Centre for Disease Control.
- GPAC guidelines are developed by BC practitioners, for BC practitioners, and are published under the brand name of BC Guidelines.
- BC Guidelines are specifically tailored to support medical practice in BC and include:
  - Medication tables with PharmaCare prices and coverage information;
  - Information on Medical Service Plan billing rules;
  - Linkages to the General Practice Services Committee incentives fees;
  - Details on the prices and availability of diagnostic and lab tests in BC; and
  - Patient resource guides, including resources and support services available to patients, families, and caregivers in BC.
- BC Guidelines target BC family physicians, Nurse Practitioners (NPs), family medicine residents, and medical students. Additional audiences include pharmacists, nurses, patients, families, and caregivers.
- BC Guidelines are freely available on www.BCGuidelines.ca, and through a mobile app, which can be used at the point of care in urban, rural, and remote locations across the province.
- The BC Guidelines website received over 229,000 total visits in 2020.[3]
- There are currently 56 clinical practice guidelines published on the BC Guidelines website.[4] Recently developed guidelines include:
  - Appropriate Imaging
  - Cardiovascular Disease
  - Hypertension
  - Microscopic Hematuria
  - Prostate Cancer
  - MRI and CT Prioritization
  - Opioid Use Disorder
  - Urinary Tract Infections

[1] Medicare Protection Act – 2014 Section 5(1) (o)
[2] 2019 Physician Master Agreement – Article 10.4
[3] GPAC 2020 Web Analytics Annual Report (internal document prepared using analytics tool in CMS Lite)
[4] GPAC website, https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

# LEGISLATIVE SESSION - FACT SHEET

Committee Membership

- GPAC is a highly collegial collaboration between the DoBC and the Ministry. It consists of an Executive and a General Committee, which are co-chaired by a representative from the DoBC and a representative from the Ministry.
- The GPAC Executive Committee provides strategic leadership, while the GPAC General Committee provides expert clinical feedback on guideline development. GPAC membership includes practicing physicians (General Practitioners and specialists), a primary care NP, pharmacists, MSC medical consultants, and employees of the DoBC and the Ministry.
- Committee members are selected to provide the GPAC with a balance of clinical specialties, academic knowledge, and research expertise.

Guideline Development Process

- Topic Selection - there are a number of factors that guide the selection of topics for BC Guidelines, including topics suggested by key stakeholders and current BC Guidelines that require updating. All topics selected must align with the Ministry, DoBC, and MSC direction:
  - Addressing common areas of care (e.g., diseases, conditions, procedures, treatments);
  - Representing a significant health system cost (financial or social);
  - Focussing on areas where there is evidence;
  - Focussing on areas where there may be variation or confusion in practice within BC; and
  - Being measurable either in practice change or patient outcomes.
- Working Groups - GPAC's evidence-based, clinical practice guidelines are developed by a working group that reviews the scientific literature, drafts the guideline, and provides essential clinical content. The working group membership is approved by the GPAC Executive and consists of a chair, primary care practitioners, a cross-section of relevant specialists, an MSC medical consultant, and other relevant health care professionals. The working group and guideline development process is facilitated by a Ministry Research Officer.
- External Review and Approval - all BC Guidelines undergo an external review process where the guideline is distributed to a random sample (typically 500-800) of physicians and NPs, as well as to a consistent list of key stakeholders in areas such as pharmacy, laboratory procedures, and the health authorities. Feedback from the external reviews is considered by the working group, and incorporated to produce a final version of the guideline for approval by GPAC. Final versions are presented to the MSC for approval and adoption in BC.

## FINANCIAL IMPLICATIONS

Under the *2019 Physician Master Agreement*, the Ministry provides up to $460,000 annually to support the work of GPAC.[5]

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**Approved:**
February 1, 2021 - Shana Ooms obo Ted Patterson, ADM, Primary Care Division
February 4, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[5] *2019 Physician Master Agreement – Article 10.4*

# FACT SHEET

# Health Connect Registry

## TOPIC

In BC, approximately 17.8% of the population ages 12 and over reported not having a primary care provider in 2018, down slightly from 18.2%.[1] No existing measure provides an accurate representation of the number of British Columbians who are not attached to a primary care provider, or actively seeking one (i.e. General Practitioner (GP) or Nurse Practitioner (NP). Further, there is not a consistent mechanism to track provincially how many individuals and families become attached to a primary care provider due to any system interventions, programs or initiatives. Finally, there is not a consistent process or centralized location for British Columbians to indicate they wish to gain access to a primary care provider within their community.

## KEY FACTS

- A centrally managed patient attachment registry will facilitate increased rates of patient attachment, resulting in a higher proportion of the BC population attached to a primary care provider who is most responsible for overall coordination and continuity of their care.
- In conjunction with the implementation of Primary Care Networks (PCNs) a Health Connect Registry (HCR) has been developed by HealthLink BC (HLBC).
- Individuals, their families, or persons in their care who are looking for a primary care provider can register their need on the HCR through an online registration form at www.HealthLinkBC.ca, or by calling HLBC at 8-1-1, any time of the day or night.
- The HCR will ensure:
  - A consistent and streamlined registration process for all British Columbians wishing for a primary care provider through a centralized, scalable registry;
  - Ease and consistent access for individuals, families and persons in care no matter where they are located in BC, in alignment with PCN development;
  - Privacy and information security are maintained in accordance with the Office of the Chief Information Officer's compliance standards;
  - Ongoing stakeholder engagement and communications throughout the process; and
  - Equitable access for individuals and families regardless of community PCN development progress.
- HLBC will manage the overall registration process, data collection, and ensure quality of data collected.
- Registration is free for eligible BC residents within established PCN communities.
- Patients on the HCR will be prioritized for attachment chronologically to enhance health equity.
- Priority access referral processes are being considered and developed by PCN communities.
- Attachment mechanisms will be developed at the local PCN level, and will utilize the registration information gathered within the HCR.
- With the introduction of the HCR there will be increased ability to measure the success of the PCN initiative.
- The HCR will help to provide data to target funding and services to areas of greatest need, to increase the proportion of British Columbians attached to a regular primary care provider.
- The HCR became operational and able to take public registrations as of June 2019.
- The first PCN community to launch the HCR was Ridge Meadows on December 15, 2020. Since that date an additional four PCNs have launched the Registry within their community; Kootenay Boundary, Cowichan, Chilliwack, and Oceanside.
- The Ministry anticipates the PCNs to next onboard the HCR will be: Comox, South Island (Western & Saanich Peninsula), Prince George, and East Kootenay. Launch planning for all active PCNs over the coming fiscal year in progress.
- HCR launches in communities with an established PCN, where an attachment coordinator is in place, and there is recruitment in progress and/or panel availability with current GP and NP providers.

[1] Statistics Canada, Table 13-10-0096-01, Canadian health characteristics.https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1310009601. Last accessed June 23, 2020. Note that the survey question asks if people had a regular provider; the percentage here is inferred from that result. I.e. 82.2% of British Columbians reported having a regular provider; therefore, it is inferred that 17.8% did not.

- HCR launches to date have been 'soft launches'. No public announcements, advertising limited to point of care, and active merging of existing waitlists within the community into the HCR.
- Although not yet a PCN, the Kamloops Primary Care Waitlist continues to be supported by HealthLink BC, with all active registrants moved from the waitlist to the HCR in May 2019 in alignment with the centralized registration mandate. HealthLink BC continues to support all attachment related activities for the community as they work to establish a formal PCN within their community.
- As of April 15, 2021, there are currently 11,209 citizens actively waiting for placement and 11,436 citizens attached to a primary care provider on the HCR

Registry – Citizen Process

- The HCR is a self-service portal where an individual who is looking for a GP or NP can register themselves, their families, or other persons in their care.
- Individuals are able to contact HLBC at 8-1-1 directly to assist with their registration.
- Registration eligibility is confirmed through verification of Personal Health Number, BC Residency and postal code to assure the individual lives within an active PCN area.
- On completion of registration, a unique Client ID is generated, families are linked, and email confirmation is also sent to those providing an email address.
- A PCN's Primary Attachment Coordinator (PCC) will contact registered individuals as primary care capacity (GP/NP) is identified within the community.
- Patient attachment is based on mutual agreement between the patient and care provider.

Registry – PCN Attachment and Access Journey

- In recognition of the uniqueness of each PCN, the HCR attachment process is determined at the local level, including priority or expedited placement for those individuals most in need of attachment.
- The HCR Administrative Interface self-service portal allows PCC access to registered individuals within the community, and supports quick assessment of clients' attachment requirements.
- PCC is the primary liaison between the Registry, primary care providers, and the client.
- PCC will work within their PCN community and have administrative access to patients registered within their PCN, and will be able to add additional necessary data.
- PCC will be able to view and edit records for those patients within their PCN, flag patients for priority placement, and change the status of registered patients from "active" through to "attached".
- In the interim of attachment, access will be an essential focus of the HCR. HLBC will work with each PCN to develop their presence on the PCN Online website as a central location to understand the health services accessible in a community, and efforts to achieve attachment.

General Practice Services Committee (GPSC) Supports

GPSC is providing $25,000 annually to each PCN to support local attachment mechanisms.[2]

## FINANCIAL IMPLICATIONS

The development of the HCR application was achieved through capital funding at a cost of $288,000 over 2018 and 2019; and is currently being maintained through HLBC operational web maintenance budget and resources.

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**Approved:**

April 19, 2021 - Sandra Sundhu obo Ted Patterson, ADM, Primary Care Division
April 28, 2021 - Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
May 10, 2021 - Kerri Harrison obo Philip Twyford; ADM, Finance and Corporate Services Division

[2] General Practice Services Committee Draft Annual Work Plan 2019/20

# FACT SHEET

# HealthLinkBC Core Services

## TOPIC

HealthLink BC (HLBC) provides British Columbians with free, high quality digital and telehealth services any time of the day or night. British Columbians can call 8-1-1 to speak to a health service navigator, registered nurse, registered dietitian, licensed pharmacist, qualified excerise profession or physician for health information and advice. The healthlinkbc.ca website provide health information, interactive health tools and a directory of all health and health related services across the Province.

## CURRENT SITUATION

HLBC, as an integrated partner in primary care, supports providers in their aim to achieve the highest clinical outcome for their patients by providing 24/7 access to health information, advice, and appropriately reconnecting patients to longitudinal health services within their community. The HLBC service platform is able to support specific populations, deliver focused programs and services, and respond to large-scale, provincial health concerns, leveraging efficiencies of scale, and 24/7 service readiness to improve accessibility and sustainability; as demonstrated in 8-1-1's integral role in the Province's response to the COVID-19 pandemic.

## KEY FACTS

Year over year, HLBC continues to see increased demand for services.

- Prior to the COVID-19 pandemic, HLBC had seen substantial increase in demand since 2016/17:
    - 8-1-1 service demand increased by 34% averaging 1,250 calls/day in early 2020;
    - healthlinkbc.ca saw 400% service demand, averaging 57,843 visits per day by early 2020.[1]
- During the peak of the provincial COVID-19 pandemic (Wave 1, March 2020), 8-1-1 received over 6,700 calls per day over a period of several weeks and continues to see sustained call volumes of over 3,500 calls per day.
- Following the pandemic the new daily call volume is forecasted at over 2,500 calls per day as a result of the increased awareness of 8-1-1 serices due to the pandemic.

HLBC is integral to multiple Ministry of Health and Provincial strategic initiatives, such as:

- COVID-19 pandemic response (see Fact Sheet *HealthLinkBC COVID-19 Response*)
- Emergency Health Provider Registry (see Fact Sheet *Emergency Health Provider Registry*).
- Integration of Virtual Physicians into the 8-1-1 telehealth model (HEiDi) (April 2020).
- Health Connect Registry (see Fact Sheet *Health Connect Registry*).
- Primary Care Network Online (see Fact Sheet *Primary Care Network Online*).
- HealthyFamiliesBC.ca fusion into HealthLinkBC.ca (in progress, FY2020/21).
- Patient Health Gateway (partner, in progress).

HLBC provides a three tier, multi-disciplinary online and by-phone service model to support and empower the patient through their health journey:

- **Empower:** Comprehensive self-care services online for patients to proactively manage and make their own decisions about health and wellness.
    - HealthLinkBC.ca: Comprehensive public website with current, evidence-informed information on more than 5,000 health, nutrition, medication, medical test, and physical activity topics; the HealthLinkBC Directory of over 6,000 health and health-related services across BC; interactive Symptom Checker, and over 200 HealthLinkBC Files in at least 7 languages.
    - HealthyFamiliesBC, Factsheet Generator, Brand Name Food List, Mental Health Substance Use Supports in BC, StopOverdoseBC.ca: Websites HLBC maintains or populates to augment information

[1] KDR Data Mart (Project BIU20_Web_Org)

on HealthLinkBC.ca and 8-1-1, and support initiatives of key stakeholders, such as Ministry of Mental Health and Addictions.

- **Encounter and Empower:** Collection of supportive and specialized services at 8-1-1 for callers who may require additional information, or advice through episodic (as and when) or longitudinal health events. Services are provided to BC and Yukon, and BC Ambulance Service callers who present with low-acuity (omega) concerns. Includes access to the following services, in over 130 languages and American Sign Language:
  - Navigators (24/7): Non-clinical patient navigators provide health information and service way-finding. In the 2020-2021 fiscal year, 969,943 client encounters were handled by a navigator, an average of 2,657 client encounters per day.[2] Of the calls received in the 2020-2021 fiscal year, navigators were able to fully assist approximately 57% of all callers, without transfer to an 8-1-1 health professional or another, external health service.
  - Nurses (24/7): Registered nurses provide health information, advice and care coordination, and the After-Hours Paliative Care Service. In the 2020-2021 fiscal year, 382,552 client encounters were handled by nurses; an average of 1,048 client encounters per day.[3]
  - Dietitians (Mon to Fri, 9 am to 5 pm): Registered dietitians provide nutrition information and consultation (by phone and email) with specialization in bariatrics, oncology, pediatrics, and allergy. In the 2020-2021 fiscal year, dietitians handled 11,370 client encounters, averaging 46 client encounters per day.[4]
  - Exercise Professionals (Mon to Fri, 9 am to 5 pm): Qualified exercise professionals provide physical activity information and professional guidance (by phone and email). In the 2020-2021 fiscal year, qualified exercise professionals handled 1,332 client encounters, averaging 5 client counters per day.[5]
  - Pharmacists (7days/week, 5 pm to 9 am): Licensed pharmacists provide information and advice on medication, both prescription and over-the-counter. In the 2020-2021 fiscal year, pharmacists handled 21,285 client encounters; an average of 58 client encounters per day.[6]
  - Virtual Physicians (7 days/week, 9 am to 11 pm): physicians available virtually from across British Columbina (by Zoom phone or video), for medical assessment of callers with an 8-1-1 nurse-determined disposition to seek care in the next 12 to 24 hours. From April 2020 to March 2021, 8-1-1 virtual physicians have completed 30,945 consults.[7]

## FINANCIAL IMPLICATIONS

- For 2019/20, HLBC's expenditures were $29.4 million.
- For 2020/21, HLBC's expenditures were $38.2 million.

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**Approved:**

April 19, 2021 - Sandra Sundhu obo Ted Patterson, ADM, HealthLink, Primary Care Division

April 23, 2021 – Peter Klotz, A/CFO obo Philip Twyford ADM, Finance and Corporate Services Division

[2] Symmetrics NVISION Data Mart BIU21_ NAV_ Org

[3] KDR Data Mart (Project BIU21_NS_Org)

[4] KDR Data Mart (Project BIU21_DS_Org)

[5] KDR Data Mart (Project BIU21_PAS_Org)

[6] KDR Data Mart (Project BIU21_PS_Org)

[7] KDR Data Mart (HEiDi_Summary_2020

# LEGISLATIVE SESSION - FACT SHEET

## Indigenous Primary Care

### TOPIC

- In 2018/19, the Ministry of Health launched a transformational team-based primary care strategy, envisioned to increase patient attachment and access to quality, comprehensive, culturally safe, and person-centred primary care services across the province. The primary care strategy includes a focus on engaging and partnering with Indigenous communities to improve access to culturally safe primary care.
- Primary Care Networks (PCNs) throughout the Province have identified both primary care service gaps for Indigenous peoples and the human resources required to address these gaps. These human resources include, but are not limited to: Traditional Healers, Elders, Navigators, Family Physicians (FPs), Nurse Practitioners (NPs) and mental health professionals.

### CURRENT SITUATION

- As of March 2021, across PCNs in BC, the Ministry has funded 112.25 Full Time Equivalent (FTE)s, with clinical and Indigenous team components, to directly support Indigenous peoples.[1]
- As part of the primary care strategy, the First Nations-led Primary Health Care Initiative supported by the Ministry and led by First Nations Health Authority (FNHA), is developing up to 15 First Nations Primary Care Centres (FNPCC) in both urban and rural BC settings over four years. The FNPCC model will enable team-based, culturally safe primary health care and access to social services for Indigenous peoples. FNPCC models combine both Western and Indigenous approaches to health and wellness, incorporate and promote First Nations' knowledge, beliefs, values, practices, and employ holistic models of health and healing.
- The first FNPCC under the First Nations-led Public Health Initiative, Lu'ma, received enhancement funding in September 2019 to enable the clinic to attach more Indigenous patients, and to offer a broader range of primary care and social services. The Ministry provided funding for 8.55 FTE and FNHA-funded 3.45 FTEs for a total of 12.0 FTEs. The proposed enhancement is on track to provide supports for patients visiting the clinic, and to attach an additional 1,750 patients over 3 years.[2]
- To date, Lu'ma has hired 1.0 FTE FPs and 0.75 FTE Nurse Practitioners (NPs) who have attached over 220 new patients. Lu'ma waitlisted patients will be attached, pending successful hiring of the remaining 1.0 FTE FP. Lu'ma Medical Clinic is actively recruiting, and in response to COVID-19, have enhanced their crisis support for patients.[3]



- Sts'ailes received service plan development funding in August 21, 2020, and a service plan is expected in February 2021 with scheduled opening, once the land is developed in December 2022.

### KEY FACTS

- 5.9% of British Columbians (approximately 270,585) self-identify as Indigenous, which includes First Nations (172,520), Métis (89,405), and Inuit (1,615) peoples.[4]
- Of the 172,520 British Columbians who self-identify as First Nations, 82,913 (48.1%) live in community (i.e. on reserve), while the rest (51.9%) live away from community (i.e. off reserve).[5]
- There are 203 First Nations Communities, 38 Métis Charted Communities, and 25 Aboriginal Friendship

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[1] Data retrieved from Primary Care Network Funding Letters and Change Requests through December 2020 for the following PCNs: Fraser Northwest, Ridge Meadows, Chilliwack, Mission, Kootenay Boundary, South Okanagan Similkameen, Central Interior Rural, Central Okanagan, East Kootenay, Prince George, North Shore, Vancouver, Western Communities, South Island Saanich Peninsula, Comox, Cowichan Valley, Oceanside.

[2] Data retrieved from February 2020 Lu'ma Medical Centre Funding Letter.

[3] Data retrieved from January 8, 2021 VCHA Physician Relations and Compensation and December 12, 2020 quarterly Lu'ma data report.

[4] Statistics Canada. 2017. Focus on Geography Series, 2016 Census. Statistics Canada Catalogue no. 98-404-X2016001. Retrieved online January 18, 2021 from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-PR-Eng.cfm?TOPIC=9&LANG=Eng&GK=PR&GC=59. "Multiple Aboriginal identities" and "Aboriginal identities not included elsewhere" make up the remaining 7,100 people who self-identify as Indigenous.

[5] First Nations Regional Health Survey: Phase 3 (2015-17), p. 17. 2019. *First Nations Health Authority*. Retrieved online January 18, 2021 from https://www.fnha.ca/Documents/FNHA-First-Nations-Regional-Health-Survey-Phase-3-2015-2017-BC-Provincial-Report.pdf

Centres across BC.[6] The Ministry, including the Primary Care Division, have partnerships with the FNHA, Métis Nation BC, and the BC Association of Aboriginal Friendship Centres. These partners support collaborative efforts to promote culturally safe and appropriate primary health care for Indigenous peoples in BC.

- Status First Nations individuals experience shorter life expectancy, higher infant mortality rates, higher youth suicide rates, and higher diabetes prevalence.[7]
- First Nations females are almost twice as likely as non-First Nations females, and First Nations males are 70% more likely than non-First Nations males to visit the emergency department.[8]

PCNs and Indigenous Peoples

- As part of the collaboration process for PCNs, the Ministry and key stakeholders are required to engage First Nations and Métis communities, as well as Indigenous health organizations, throughout the development process including planning/service plan development, and enhancing cultural safety education and training of all PCN staff.
- Cultural safety is a core attribute of the PCN, and to support this, the FNHA and the Ministry have developed the *Indigenous Engagement and Cultural Safety Guidebook: A Resource for Primary Care Networks*[9], which is currently being disseminated to PCN communities.

Other Initiatives to Improve Primary Care for Indigenous Peoples

- The dual public health emergencies of the COVID-19 pandemic and the overdose crisis, compounded by systemic racism in the health care system, have resulted in calls to accelerate primary care access for rural and Indigenous peoples. As a result, new virtual pathways to improve access to health care services for Indigenous citizens and their families were fast-tracked during the pandemic.
- FNHA, with financial support from the Ministry, successfully launched the First Nations Virtual Doctor of the Day (FNvDOD) on April 1, 2020, and the First Nations Virtual Substance Use and Psychiatry Service (FNvSUPs) on August 17, 2020. Part of a larger suite of virtual care services provided under the Real Time Virtual Support (RTVS) program, FNvDOD and FNvSUPs provide culturally safe care to Indigenous people in BC who have limited access in their communities to physicians, and specialists in addictions medicine and psychiatry.
- The Joint Project Board (JPB), comprised of the Ministry and FNHA, support alignment of initiatives and services, while identifying and removing barriers to health service delivery and access in the following areas: mental health and substance use; primary care; maternal and child health; and oral health.
- Annual JPB funding currently supports 27 primary and community care projects across the province. Examples of approved projects include multi-disciplinary teams with FP/NP leads; Indigenous patient navigators; mobile mental health and crisis response units, and other shared mental health services for children, youth, and adults; and a wrap-around chronic disease management and prevention team.

## FINANCIAL IMPLICATIONS

- In 2019/20, the Ministry provided $13.17 million to the FNHA to support JPB primary and community care projects across the province.
- In 2020/21, the Ministry has provided $10.97 million by Funding Letter Update #3.
- Annual operating funding of up to $1.97 million, plus one-time costs of up to $0.26 million, have been approved for the Lu'ma Medical Clinic (of which the Ministry will fund $1.78 million and the FNHA will fund $0.45 million).

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**Approved:**

February 1, 2021 – Shana Ooms obo Ted Patterson, ADM, Primary Care Division
February 12, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information Analysis and Reporting Division
February 23, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

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[6] Content Office of Indigenous Health, online February 9, 2021 from; and January 18, 2021 from https://www.mnbc.ca/about; https://bcaafc.com/
[7] Office of the Provincial Health Officer and FNHA. *Indigenous Health and Well-Being* (2018). Retrieved online January 18, 2021 from https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/indigenous-health-well-being-2018.pdf
[8] First Nations Health Status & Health Services Utilization. p 5. 2016. *First Nations Health Authority*. Retrieved online January 18, 2021 from https://www.fnha.ca/WellnessSite/WellnessDocuments/FNHA-First-Nations-Health-Status-and-Health-Services-Utilization.pdf
[9] https://www.pcnbc.ca/media/pcn/PCN_Guidebook-Indigenous_Engagement_and_Cultural_Safety_v1.0.pdf

# LEGISLATIVE SESSION - FACT SHEET

## Patients as Partners

### TOPIC

In 2017, the Ministry of Health launched a transformational team-based primary health-care strategy, envisioned to increase patient attachment and access to quality, comprehensive, culturally safe, and person-centred primary care services across the province. The Patients as Partners Initiative provides person and family-centred health care, engagement, and self-management resources and supports with the goal of supporting the strategy by improving population health outcomes, improving patient and health care provider experience of care, and lowering health care costs. Oversight of contract deliverables ensures they support the Ministry's priorities, provide value for money, and benefit users. Funding was provided in 2019/20 and is available for 2020/21.

### CURRENT SITUATION

- Patients as Partners provides tools, resources, and services that encourage patients and family caregivers to increase their health knowledge, and to take command of their health at home, in their community, and within the healthcare system. Patients as Partners also makes tools and resources available to health sector staff to encourage a person- and family-centred approach to care. Services are provided on three levels:
    1. **Individual Level:** Health care improvements, education, and tools are supported at the direct care interaction between the patient/family/caregiver and the health care provider/team to create reciprocal accountability. Studies show that patients who are more engaged in their own health care have better health outcomes and an improved experience of care.[1] Examples include patients participating in self-management and peer support programs, using tools and resources to manage their chronic diseases, and/or make health care decisions. All contractors have materials and/or programs for multicultural and/or Indigenous audiences.
    2. **Community Level:** Engagements and self-management activities are provided at the community level; these services are not offered by health authorities or physicians/family practices. An example is the hundreds of Chinese or South Asian patients and families who participated in the interCultural Online Health Network's chronic disease self-management events to learn in their first language how to improve their health, and decrease unplanned hospital visits.
    3. **System Level:** Educational resources and engagement services are provided to support health system redesign and quality improvement efforts. This includes providing online resources and training on best practices for patient and public engagement. Examples include planning and conducting Primary Care Network branding engagements in 2019/20 that included patients and families, health care providers, and administrators, and iCON's ongoing work with the First Nations Health Authority, Indigenous Elders, health providers, and other partners about understanding how and why to incorporate Indigenous Traditional healing in health care plans.
- The Institute for Healthcare Improvement's Triple Aim faculty asserts: "*By engaging patients and families at multiple levels of organizational performance, we can not only improve their own health care experiences, but also gain valuable insights for actions necessary to improve the health of populations and to extract greater value from our limited health resources*."[2]

### KEY FACTS

Patients as Partners 2019/20 and 20/21 initiatives included the following:

- **Delaney and Associates** provides training in facilitation and best practices in patient and public engagement. Based on contract reporting in 2019/20, events and services were provided to 111 patients, families and caregivers, 592 health sector staff and volunteers, and 37 health care providers.[3]
- **Family Caregivers of BC (FCBC)** develops and enhances community supports for caregivers of family members who are in poor health, elderly, and/or disabled, to enable them to be at home as long as possible.

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[1] Regional Primary Care Coalition, Patient Engagement – A framework for improving health and lowering costs, June 2012, p.1. Accessed Feb 11, 2019.
[2] Ibid
3 Unpublished data self-reported by Delaney and Associates Inc. for fiscal 2019/20 as part of contractual obligations to the Ministry

Based on contract reporting in 2019/20, FCBC provided education and support services to more than 2,900 family caregivers and more than 55 health sector staff, volunteers, and health care providers. Resources were distributed to more than 208,000 family caregivers, health care staff and health providers. Web hits, which include accessing resource materials, were over 226,000.[4]

- **University of Victoria Self-Management** provides evidence-based, interactive, peer-led programs, peer-coaching, and provides resources that teach chronic disease self-management activities and practical self-care skills to people and their family members. Based on contract reporting in 2019/20, they provided self-management training, coaching, and support to more than 3,000 patients, families, and caregivers. Over 48,000 individuals received resources and their website received 129,284 web hits.[5]
- **interCultural Online Health Network (iCON), UBC Faculty of Medicine** provides culturally relevant, linguistically appropriate, trusted chronic disease health information for multicultural populations, and educational sessions on why and how to include Indigenous Traditional healing in health care plans. From contract reporting in 2019/20, iCON provided educational events and services to 1,022 patients, families, caregivers, health care providers, health sector staff, and volunteers. They had more than 23,000 web and social media hits, not including their reach by radio and other multi-channel broadcasting.[6]
- **The Centre for Collaboration, Motivation and Innovation (CCMI)** is BC's licensed provider of Brief Action Planning, a person-centred self-management support tool for behaviour change, coupled with associated training including motivational interviewing, informed decision making, brief interventions, and person and family-centred health care. They also provide the quality improvement work to embed self-management supports into physician practices, health authorities, and other community services. Based on contract reporting in 2019/20, CCMI provided training to more than 1,000 health sector staff, volunteers, and health care providers, often using a train-the-trainer approach. Over 33,000 web hits included access to resources.[7]
- **Pain BC** provides tools and resources for patients to increase their skills and confidence to manage their chronic pain, improve their quality of life, and reduce health care system usage. Based on contract reporting in 2019/20, Pain BC provided direct education/support services to over 2,200 patients, families, and caregivers, and over 1,700 health care providers and staff. Their resources were distributed to more than 275,000 patients, families and caregivers, and their website received over 350,000 hits.[8]

## FINANCIAL IMPLICATIONS

- The Ministry provided the following payments for 2019/20 and has forecasted funding up to the amounts identified for 2020/21 (see table below).

| Provider | 2019/2020 Actuals | 2020/21 Available Funding |
|---|---|---|
| Delaney and Associates | $252,800 | $450,000 |
| Family Caregivers of BC | $466,113 | $500,000 |
| University of Victoria Self-Management | $2,450,498 | $2,484,000 |
| UBC iCON | $699,585 | $785,000 |
| CCMI | $495,300 | $750,000 |
| Pain BC | $740,168 | $750,000 |
| **Total** | **$5,091,153** | **$5,719,000** |

- In response to the COVID-19 pandemic, FCBC received an additional $500,000 to provide further supports to family caregivers through to July 2022.[9]

**Approved:**
February 5, 2021 - Shana Ooms obo Ted Patterson, ADM, Primary Care Division
February 15, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
April 14, 2021- Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

4 Unpublished data self-reported by FCBC for fiscal 2019/20 as part of contractual obligations to the Ministry.
5 Unpublished data self-reported by University of Victoria Self-Management for fiscal 2019/20 as part of contractual obligations to the Ministry.
6 Unpublished data self-reported by iCON for fiscal 2019/20 as part of contractual obligations to the Ministry.
7 Unpublished data self-reported by CCMI for fiscal 2019/20 as part of contractual obligations to the Ministry.
8 Unpublished data self-reported by Pain BC for fiscal 2019/20 as part of contractual obligations to the Ministry.
9 MOH News Release. April 26, 2020. More support for family caregivers during COVID-19. https://news.gov.bc.ca/releases/2020HLTH0141- 000763

# LEGISLATIVE SESSION - FACT SHEET

## Primary Care Access in Rural and Remote Communities

### TOPIC

- In 2018/19, the Ministry of Health launched a transformational team-based primary care strategy, envisioned to increase patient attachment and access to quality, comprehensive, culturally safe, and person-centred primary care services. The 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.
- Access to and provision of primary care services in rural and remote communities is constrained by small populations, large geographic areas, long distances between communities, few publicly-funded transportation options, inclement weather, and fluctuations in the availability of health care professionals.
- Solutions to improve rural primary care access include innovative service delivery models of virtually enabled care, mobile services to decrease the constraints of distance and inclement weather, and a focus on how health care professionals are remunerated, recruited, retained, and deployed.[1]
- Team-based primary care in rural and remote communities uses a number of different service models.[2] These service models and all primary care providers in a defined geography will be aligned together in local Primary Care Networks (PCNs), including in-person services, virtually enabled services, and mobile services.

### CURRENT SITUATION

COVID Response

- The Rural, Remote and Indigenous COVID-19 Framework,[3] intended to address health equity, has informed the delivery of comprehensive, virtually enabled primary care and access to specialists. The Framework has enabled and influenced the COVID -19 response (see bullet below) in the development of clinical pathways, transportation options, advisement on cohort of patients, and patient autonomy.
- Together with the First Nations Health Authority, Northern Health Authority (NHA) and the Ministry, in response to the COVID-19 pandemic, the Ministry provided urgent funding to the Real-Time Virtual Support (RTVS) program for rural and Indigenous populations to increase access to virtually enabled care. Key initiatives include HealthLink BC Emergency iDoctor-in-assistance program, First Nations Virtual Doctor of the Day, First Nations Virtual Substance Use and Psychiatry Services, the Rural Urgent Doctors in-aid program, Rural Outreach Support program (ROSe), Child Health Advice in Real-Time Electronically program, and Maternity and Babies Advice Line. As of April, 2021, Ministry has provided continued funding.
- NHA has established the Northern Health Virtual Clinic for virtual primary and community care services to patients across the north, including many from rural and remote areas.
- The Critical Outreach and Diagnostic Intervention (CODI) pilot program's success established the groundwork for the RTVS initiatives, with the CODI smartphone app being used as the prototype for ROSe which currently supports rural providers by providing 24/7 intensivist/critical care via Zoom.

PCN Planning and Implementation

- PCN implementation is well underway, and as of December 2020, a total of 39 PCNs are at various stages of implementation (Year 1, Year 2) across the Province, many of which are located in rural regions including Kootenay Boundary, Pacific Northwest, North Peace, Northern Interior, East Kootenay, and Central Interior.
- Existing networks of primary care providers and health authority inter-professional teams in the north have provided a similar function to PCNs, and some are being resourced to become fully integrated PCNs. First Nations-led Primary Health Care Centres , which will provide both western and Indigenous focused primary care, are being planned in both rural and urban areas in the province ( *Indigenous Primary Care* Fact Sheet).

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[1] See *Sustainability of Maternity Services at Small rural 1A Sites* Fact Sheet for more information.

[2] Clinical models are as follows: full-service Family Practices/Patient Medical Homes (PMHs); Urgent and Primary Care Centres (UPCCs); Community Health Centers (CHCs); First Nations Primary Care Clinics (FNPCCs).

[3] 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

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

Demographics

- Approximately 16.2% of British Columbians live in rural or remote areas of BC[4] 30.3% of Indigenous peoples in BC live in rural areas.[5]
- Rural British Columbians are more likely to die prematurely from circulatory diseases, all injuries, poisonings, motor vehicle accidents, and suicide, compared to citizens in urban areas of the province.[6]

Maternity Services Overview

- The Provincial Health Services Authority, in collaboration with the Ministry, is developing a provincial maternity services strategy to stabilize and sustain maternity services, including rural and remote regions.
- The provision of maternity care services for British Columbians living in rural and remote communities has unique challenges, and the ability of birthing people living in these areas to deliver babies in their local community has steadily declined over the past 21 years (23 maternity sites have closed since 2000).[7]
- Rural maternity sites have closed for a variety of reasons, including the centralization of surgical services over time, perinatal nursing shortages, insufficient support networks for maternity care providers, the 24-hour nature of the service, challenges with recruitment and retention, and the issues of fee-for-service compensation in low-volume birth settings.
- Low-risk maternity services (e.g. services without surgical caesarean-section back-up) are being offered in some rural communities. These services require participation and partnership between physicians, nurses, midwives, and health authorities. A successful example is the Haida Gwaii low-risk maternity service.

Other Initiatives to Improve Rural and Remote Primary Care Access

- The *Rural Coordination Centre of BC* supports several initiatives and collaborative networks focused on improving rural health care service delivery, including supporting rural communities to participate in PCN development, and virtually enabled care collaborative networks. These include Enhanced Surgical Skills Network, Rural Surgical and Obstetrical Network, and the Family Practice Anaesthesia Network.[8]
- Several innovative models of primary care have been implemented in rural and remote communities over the past few years, in partnership between health authorities, Doctors of BC, and Divisions of Family Practice, including Northern Health Virtual Clinic, the Real-Time Virtual Support pathways, and Interior Health's TeleThoracic Surgery program.[9]
- The Community Paramedicine program realized its goal of creating 80 new full-time-equivalent paramedic positions in 99 rural and remote communities, to provide a local resource for health promotion, prevention, and support of older adults in monitoring and managing chronic conditions.[10]

## FINANCIAL IMPLICATIONS

- *Budget 2021* includes $253M over 3 years ($63M; $95M; $95M) to continue to expand team-based and urgent primary care. This builds on funding allocated in *Budget 2018* to support recruitment of primary care health professionals for team-based care (including additional GPs and NPs) and to pilot innovation hubs. *Budget 2018* year-3 allocation of $153M continues as part of the Ministry's base budget ($458M over 3 years). Total net new funding for the Primary Care Strategy is $711M over 3 years ($215M/ $248M; $248M).
- In 2020/21, the Ministry approved additional RTVS operating funding of up to $8.7M (which includes First Nations Virtual Doctor of the Day and Virtual Substance Use and Psychiatry Service) and $3.6M for Enhanced Access to Primary and Specialist Care.

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[4] BC Stats. 2019 Population Estimates (PEOPLE2020). & Ministry of Health, Community Health Service Area (CHSA) Urban-Rural Classification (2018).
[5] Statistics Canada, 2016 Census. Accessed January 20, 2021, from https://www2.gov.bc.ca/gov/content/data/statistics/infoline/infoline-2017/17-138-2016-census-indigenous-people-canada
[6] Kulig, J.C. & Williams, A.M. (2011). Health in rural Canada. UBC Press, Vancouver, p. 23. https://www.ubcpress.ca/asset/9079/1/9780774821728.pdf
[7] Sustaining 1A Maternity Sites in BC: Proposal to the JSC on Rural Issues. Submitted by UBC Centre for Rural Health Research, January 11, 2019. \\sfp.idir.bcgov\S114\S15015\Strategic Programs & Initiatives (40560-30)\Maternity
[8] https://rccbc.ca/rccbc-initiatives/rural-health-services-support-initiativesnetworks/. Accessed January 20, 2020.
[9] https://www.infoway-inforoute.ca/en/what-we-do/blog/174-what-we-do/digital-health-and-you/stories/clinician-stories/67-a-thoracic-surgeon-talks-about-the-benefits-of-telemedicine. Accessed June 8, 2020.
[10] http://www.bcehs.ca/our-services/programs-services/community-paramedicine. Accessed January 20, 2021.

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
March 1, 2021 - Shana Ooms obo Ted Patterson, ADM, Primary Care Division
March 16, 2021 - Martin Wright, ADM, Health Sector Information, Analysis & Planning & Reporting Division
April 14, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
May 13, 2021 - Kerri Harrison obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Primary Care Attachment in BC

### TOPIC

- Launched in 2018/19, 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. The Province is committed to increasing attachment through establishing Primary Care Networks (PCNs) that will cover all 218 Community Health Service Areas (CHSAs) across the province.
- As of March 3, 2021, a total of 47 PCNs are at various stages of implementation (Year 1, Year 2)[1]. The 2021/22 – 2023/24 Ministry of Health Service Plan sets the following targets for PCNs operating, or in implementation: 2020/21: 53[2]; 2021/22: 65; 2022/23: 85; 2023/24: 85.
- It is expected that greater than 80% of CHSAs in regional health authorities are covered by PCNs by end of 2021, and that more than 70% of approved net new Family Physicians (FPs), Nurse Practitioners (NPs), nursing, and allied health staff are recruited against planned Full-time Equivalent (FTE) allocations.
- The BC attachment target is 261,045 for fiscal 2020/21 and 436,610 for the 4-year target for all PCNs[2].
- Attachment is described as the documented existence of a clear ongoing relationship between a patient and a most responsible primary care provider.

### CURRENT SITUATION

- The number of FPs in BC has grown between 2015 and 2019 at a rate surpassing all other provinces except New Brunswick and Prince Edward Island. Additionally, between 2015 and 2019, the proportion of internationally trained physicians in BC increased over 3%.[3,3]
- From 2017/18 to 2019/20, the BC Attachment Algorithm identified over 109,000 British Columbians as newly attached to a primary care provider in PCN CHSAs in BC. These individuals were either previously unattached or were unknown to have had a previous attachment relationship with a primary care provider.[4]
- The number of British Columbians aged 12 and over who report having a regular healthcare provider increased by 1.35% from 2018 to 2019.[5]
- As of January 31, 2021, an estimated 57,079 attachments ($0 attachment fee item) have occurred in PCNs across the province; representing 13% of the total 4- year provincial attachment target for PCNs[6].
- As of March 3, 2021, UPCCs have contributed a total of 13,545 attachments (self-reported), where one UPCC has 1,785 validated attachments ($0 attachment fee item)[7].
- As of March 3, 2021, 442 FTEs of net new resources in PCNs, First Nations Primary Care Centers, Community Health Centres, and NP Led Primary Care Clinics have been hired. Overall hiring is on track for Fiscal Year 2020/21 at 39% of total approved FTEs hired to date. While overall hiring is on track, only 10% of FPs (22.7 FTEs) and 61% of NPs (106.7 FTEs) have been hired to date.[9]
- Overall BC attachment rates (See Table 1) have remained steady between 2018/19 - 2019/20 at 75% of patients being attached to a practice, or 3,932,257 patients in 2019/20, and 3,870,379 patients in 2018/19.[8] This steady state, while not increasing substantively, is also not decreasing when factoring in circumstances such as population growth and unattachments due to retirements. Currently 15% of the population are unattached to a practice. However, communities with high unattachment also have PCNs in early stages of progress.

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[1] Results Management Office, Primary Care Division, . Accessed March 2021.
[2] Ibid.
[2] Forecasted at time of writing, April 2021.
[3] CIHI Report. '*Physicians in Canada, 2019',* International medical graduates: Figure 8, page 20; https://www.cihi.ca/sites/default/files/document/physicians-in-canada-report-en.pdf. Last accessed on January 15, 2021.
[4] HSIAR data, Ministry of Health, January 2021.
[5] Statistics Canada. Table 13-10-0096-01 Health characteristics, annual estimates https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1310009601. Accessed January 2021.
[6] HSIAR data, Ministry of Health, March 2021.
[7] Ibid.
[9] Ibid.
[8] HSIAR data, derived from the Attachment Algorithm, Ministry of Health, January 2021.

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

- Taken together, Primary Care policy, $0 attachment fee item codes, the BC Attachment Algorithm, the Canadian Community Health Survey, and the college of Physician and Surgeons of BC (CPSBC) are key inputs that contribute to a comprehensive picture of longitudinal, quality care for patients.
- PCNs support increased attachment by: the addition of new-to-practice (NTP) FPs and NPs; development of clear pathways, mechanisms, and protocols for patients' to maintain continuity of care and effective transitions of care; implementation of clinical service models to provide a regular place of care and support; and, introduction of a Health Connect Registry to register for a primary care provider.

**Table 1: Top 5 Unattached Populations by Health Authority (HA) and Local Health Area (LHA), 2019/2020**[9]

| HA | Top 5 Ranking HA LHAs | Top 5 LHA by Number Unattached | # Unattached to GP/NP Practice | Top 5 LHA by Percent Unattached | % Unattached to GP/NP Practice |
|---|---|---|---|---|---|
| IHA | 1 | 137 - Central Okanagan | 32,768 | 126 - Grand Forks | 23.6% |
| IHA | 2 | 143 - Kamloops | 19,242 | 133 - Keremeos | 21.3% |
| IHA | 3 | 136 - Vernon | 13,018 | 113 - Kimberley | 21.0% |
| IHA | 4 | 132 - Penticton | 7,167 | 127 - Kettle Valley | 18.9% |
| IHA | 5 | 146 - Cariboo/Chilcotin | 5,096 | 146 - Cariboo/Chilcotin | 18.7% |
| FHA | 1 | 233 - Surrey | 84,332 | 211 - Hope | 34.4% |
| FHA | 2 | 222 - Burnaby | 34,609 | 212 - Chilliwack | 24.3% |
| FHA | 3 | 224 - Tri-Cities | 31,559 | 215 - Agassiz/Harrison | 21.7% |
| FHA | 4 | 213 - Abbotsford | 30,016 | 223 - Maple Ridge/Pitt Meadows | 19.4% |
| FHA | 5 | 231 - Langley | 28,256 | 214 - Mission | 18.9% |
| VCHA | 1 | 331 - North Vancouver | 24,919 | 335 - Howe Sound | 28.1% |
| VCHA | 2 | 311 - Richmond | 22,851 | 322 - Vancouver - Centre North | 17.4% |
| VCHA | 3 | 321 - Vancouver - City Centre | 20,293 | 331 - North Vancouver | 16.2% |
| VCHA | 4 | 324 - Vancouver - Westside | 19,355 | 321 - Vancouver - City Centre | 15.4% |
| VCHA | 5 | 326 - Vancouver - South | 16,143 | 332 – W. Vancouver /Bowen Island | 13.7% |
| VIHA | 1 | 411 - Greater Victoria | 42,183 | 434 - Vancouver Island North | 39.4% |
| VIHA | 2 | 424 - Greater Nanaimo | 16,542 | 426 - Alberni/Clayoquot | 20.5% |
| VIHA | 3 | 412 - Western Communities | 15,951 | 412 - Western Communities | 17.8% |
| VIHA | 4 | 413 - Saanich Peninsula | 11,884 | 411 - Greater Victoria | 17.1% |
| VIHA | 5 | 431 - Comox Valley | 10,598 | 413 - Saanich Peninsula | 17.0% |
| NHA | 1 | 524 - Prince George | 19,537 | 532 - Peace River North | 40.6% |
| NHA | 2 | 532 - Peace River North | 15,563 | 517 - Terrace | 22.3% |
| NHA | 3 | 531 - Peace River South | 6,369 | 531 - Peace River South | 22.3% |
| NHA | 4 | 517 - Terrace | 4,901 | 524 - Prince George | 18.7% |
| NHA | 5 | 521 - Quesnel | 3,278 | 518 - Nisga'a | 18.1% |

## FINANCIAL IMPLICATIONS

*Budget 2021* includes $253M over 3 years ($63M; $95M; $95M) to continue to expand team-based and urgent primary care. This builds on funding allocated in *Budget 2018* to support recruitment of primary care health professionals for team-based care (including additional GPs and NPs) and to pilot innovation hubs. *Budget 2018* year-3 allocation of $153M continues as part of the Ministry's base budget ($458M over 3 years). Total net new funding for the Primary Care Strategy is $711M over 3 years ($215M/ $248M; $248M).

[9] Health Sector Information, Analysis and Reporting Division, Integrated Analytics: Hospital, Diagnostic and Workforce Branch, Ministry of Health. Attachment Algorithm. Unattached rates as of fiscal year 2019/20. Data as of March 1, 2021.

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
March 2, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
May 14, 2021 - Kerri Harrison obo Philip Twyford, ADM, Finance and Corporate Services Division
June 10, 2021 - Ted Patterson, ADM, Primary Care Division

# LEGISLATIVE SESSION - FACT SHEET

## Primary Care Networks

### TOPIC

- In 2018/19, the Ministry of Health launched a transformational team based primary care strategy, envisioned to increase patient attachment and access to quality, comprehensive, culturally safe, and person-centred primary care services across the province. Team-based primary care will be delivered using a number of different models including: Full-service Family Practices/Patient Medical Homes (PMHs), Urgent and Primary Care Centres, Community Health Centres, First Nations Primary Care Clinics, and Nurse Practitioner (NP) Primary Care Clinics.
- These clinical service models and all primary care providers in a defined geography will be aligned together in local Primary Care Networks (PCNs), in order to better coordinate and leverage existing and new providers and services to better meet the needs of local citizens.
- PCNs will be locally planned and delivered through partnerships including Divisions of Family Practice, health authorities (HA), First Nations, and other local community representatives.
- 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.
- The Province committed to implementing this new primary care strategy over four years beginning in 2019/2020 and is working to establish PCNs that will cover all 218 Community Health Service Areas (CHSAs).
- It is expected that greater than 80% of CHSAs in Regional HA are covered by PCNs by the end of fiscal year 2020/21; and that recruitment of approved net new Family Physicians (FPs), NPs, nursing, and allied health staff is at greater than 70% filled against planned full-time equivalent (FTE) allocations for the year[1].

### CURRENT SITUATION

- As of March 3, 2021, 47 PCNs are in their first or second year of implementation (Year 1, Year 2) across the province. The 2021/22 – 2023/24 Ministry of Health Service Plan sets the following targets for PCNs operating, or in implementation: 2020/21: 53[2]; 2021/22: 65; 2022/23: 85; 2023/24: 85.
- As of March 3, 2021, the number of CHSAs covered by all models of care associated with a PCN (both in planning and in implementation) equals 174 CHSAs, or approximately 79% coverage.
- As of March 3, 2021, 442 FTEs of net new resources in PCNs, including First Nations Primary Care Centers, Community Health Centres, and NP Primary Care Clinics have been hired. Overall hiring is on track for fiscal year 2020/21 at 39% of total approved FTEs hired to date. While overall hiring is on track, only 10% of FPs (22.7 FTEs) and 61% of NPs (106.7 FTEs) have been hired to date.[3]

### KEY FACTS

- PCNs are a unified system of primary care where PMHs and other clinical service models are networked with each other and with primary care services, delivered or contracted by HAs, and community-based health and social service organizations.
- Team-based care optimizes the skills of valued health-care professionals, where providers work together to provide comprehensive care. This includes FPs, NPs, nursing, pharmacists, and other allied staff including Traditional Healers, Elders, social workers, and mental health and substance use clinicians.
- PCNs are supported through a collaborative governance model and a local PCN Steering Committee that is intended to reflect and prioritize the primary care needs of a community. Decisions are made regarding service redesign and clinical service models, including support and integration of team-based providers and new facilities. Partners, through Collaborative Services Committees (CSCs), work together to create a service plan, outlining current primary care gaps, and the resources required to fill those gaps. These gaps will be supported by inter-disciplinary providers, either on contract or employed by the regional HA on behalf of the PCN. 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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[1] Regional Health Authority Bilateral / Executive Mandate Letter - 2020/2021. Pg. 6, 2020.

[2] Forecasted at time of writing, April 2021. Includes PCNs in tables below plus Nanaimo (2) and Victoria (4) PCNs.

[3] Health Sector Information and Analytics Reporting (HSIAR), MoH, March 2021; does not include hiring within Urgent and Primary Care Centres.

# LEGISLATIVE SESSION - FACT SHEET

**PCNs in Year 1 (Y1) and Year 2 (Y2) of Implementation as of March 2021**

The first cohort of communities (Y2) received funding for PCN Service Plan implementation in May 2019 with the exception of Saanich Peninsula and Western Communities which were approved late 2019/20. The second cohort of communities (Y1) received initial funding for PCN Service Plan implementation in February 2020. In addition, Northern Interior Rural and North Peace (8 PCNs) received approval letters in January 2021, and PCNs in Nanaimo (2) and Victoria (4) are approved for implementation in 2021/22.

| PCNs in Year 2 of Implementation[4] | | | |
|---|---|---|---|
| **Community** | **Number of PCNs** | **Attachment Target** | **Annual Funding** |
| Burnaby | 3 | 32,000 | $10,087,930 |
| Comox Valley | 1 | 825 | $2,237,585 |
| Fraser North West | 4 | 43,065 | $12,299,808 |
| Kootenay Boundary | 1 | 15,250 | $5,248,613 |
| Prince George | 1 | 2,000 | $3,663,180 |
| Ridge Meadows | 2 | 19,238 | $2,920,270 |
| Richmond | 3 | 56,500 | $15,358,450 |
| South Okanagan Similkameen (SOS) | 1 | 11,350 | $4,511,850 |
| Vancouver Part 1 | 2 | 52,900 | $15,332,452 |
| **TOTAL** | **18** | **233,128** | **$71,660,138** |

| PCNs in Year 1 of Implementation[4] | | | |
|---|---|---|---|
| **Community** | **Number of PCNs** | **Attachment Target** | **Annual Funding** |
| Central Interior Rural Division (CIRD) | 1 | 6,952 | $4,542,161 |
| Central Okanagan | 3 | 28,580 | $11,392,106 |
| Chilliwack | 3 | 28,650 | $11,952,210 |
| Cowichan Valley | 1 | 16,750 | $6,871,763 |
| East Kootenay | 1 | 18,217 | $9,111,083 |
| Mission | 1 | 11,580 | $3,815,136 |
| North Shore (North Vancouver) | 3 | 28,025 | $11,358,592 |
| Oceanside | 1 | 11,950 | $4,651,903 |
| Saanich Peninsula | 1 | 14,800 | $5,182,599 |
| Vancouver (Part 2 - Growth Plan) | 4 | 66,250 | $20,011,715 |
| Western Communities | 1 | 36,475 | $10,622,663 |
| White Rock South Surrey | 1 | 8,900 | $4,226,299 |
| **TOTAL** | **21** | **277,129** | **$103,738,230** |

| PCNs Newly Implemented[4] | | | |
|---|---|---|---|
| **Community** | **Number of PCNs** | **Attachment Target** | **Annual Funding** |
| Northern Interior Rural (NIRD) | 7 | 6,193 | $4,407,969 |
| North Peace | 1 | 3,500 | $2,081,987 |
| **TOTAL** | **8** | **9,693** | **$6,489,956** |

## FINANCIAL IMPLICATIONS

*Budget 2021* includes $253M over 3 years ($63M; $95M; $95M) to continue to expand team-based and urgent primary care. This builds on funding allocated in *Budget 2018* to support recruitment of primary care health professionals for team-based care (including additional GPs and NPs) and to pilot innovation hubs. *Budget 2018* year-3 allocation of $153M continues as part of the Ministry's base budget ($458M over 3 years). Total net new funding for the Primary Care Strategy is $711M over t3years ($215M/ $248M; $248M).

**Approved:**

February 24, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information Analysis and Reporting
March 15, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
May 14, 2021- Kerri Harrison obo Philip Twyford, ADM Finance and Corporate Services
June 10, 2021 - Ted Patterson, ADM, Primary Care Division

[4] Data complied by Primary Care Division, Results Management Office, Ministry of Health, March 2021, from PCN Service Plans and associated funding Schedules. Annual funding is annualised funding at full implementation of the PCN.

# LEGISLATIVE SESSION - FACT SHEET

## Primary Care Strategy Overview

### TOPIC

- In 2018/19, the Ministry of Health launched a transformational team-based primary care strategy, envisioned to increase patient attachment and access to quality, comprehensive, culturally safe, and person-centred primary care services across the province. Team-based primary care will be delivered using a number of different models including:
  - Full-service Family Practices/Patient Medical Homes (PMHs)
  - Urgent and Primary Care Centres (UPCCs)
  - Community Health Centres (CHCs)
  - First Nations Primary Care Clinics (FNPCCs)
  - Nurse Practitioner (NP) Primary Care Clinics (NPPCCs)
- These clinical service models and all primary care providers in a defined geography will be aligned together in local Primary Care Networks (PCNs), in order to better coordinate and leverage existing and new providers and services to better meet the needs of local citizens.
- PCNs will be locally planned and delivered through partnerships including Divisions of Family Practice (DoFP), health authorities, First Nations, and other local community representatives.
- This 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.
- The primary care strategy also includes cultural safety and humility in primary care, the Health Connect Registry (HCR)[1], the PCNs public-facing website (PCN Online), and Virtually Enabled Primary Care pathways. These resources will assist with the coordination and advancement of the primary care strategy across the Province.

### CURRENT SITUATION

Implementation of the primary care strategy is well underway. As of March 3, 2021:

- There are 47 PCNs in their first or second year of implementation (Year 1, Year 2) across the province. The 2021/22 – 2023/24 Ministry of Health Service Plan sets the following targets for PCNs operating, or in implementation: 2020/21: 53[2]; 2021/22: 65; 2022/23: 85; 2023/24: 85.
- There is a provincial commitment of up to 30 UPCCs across the province by December 2021. As of March 3, 2021, 21 UPCCs are operational with 9 more in planning.
- One new CHC and 2 significantly expanded CHCs are fully operational, with 2 additional CHCs in early planning, for a total of 5.
- One FNPCC has been implemented with several more expected in the coming year.
- Three NPPCCs have been implemented across the province.

### KEY FACTS

- Approximately 17.7% of British Columbians report not having a regular primary care provider.[3]
- Only 45.4% of British Columbians report being able to access same or next day appointments with their primary care providers.[4]
- Team-based care will optimize the skills of valued health-care professionals, where various providers work alongside other health-care professionals to provide comprehensive care to patients. This includes Family Physicians (FPs), NPs, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), clinical pharmacists, and

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[1] See Health Connect Registry Fact Sheet

[2] Forecasted at time of writing, April 2021.

[3] Statistics Canada, Table 13-10-0096-16, Has a regular healthcare provider, by age group, Canadian health characteristics, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009616&pickMembers%5B0%5D=1.11&pickMembers%5B1%5D=3.1 Last Accessed January 20, 2021.

[4] CIHI, Commonwealth Fund survey, 2017. Accessed file "cmwf-2017-data-tables-en-web.xlsx" from https://www.cihi.ca/en/commonwealth-fund-survey-2017, January 20, 2021.

other allied health professionals such as physiotherapists, occupational therapists, traditional healers, elders, social workers, and mental health and substance use workers.

- Building on investments by the General Practice Services Committee (GPSC) to support FPs as they transition to the PMH model (i.e. where patients have a regular provider to oversee their longitudinal care), health authorities have been working with DoFP and FNHA locally to undertake implementation of PCNs.
- PCNs are a unified system of primary care, where PMHs, a family practice or health authority primary care clinic, and other clinical models of care are networked with each other and with primary care services, delivered or contracted by health authorities, and health and social service organizations. Within a PCN, patients, families, and caregivers can access comprehensive, person-centred, culturally safe, and quality primary care. PCNs maintain clear pathways with specialized community services programs and the broader system.
- Development of PMHs across the province will enhance primary care capacity, increase coordination and continuity of care, and serve to decrease the variability of primary care services, so that all British Columbians will have access to quality primary care services.
- UPCCs provide a flexible resource to meet both the urgent unplanned and ongoing planned primary care needs of people in communities across the province. UPCCs fulfill service gaps in select urban and metro communities and are a full-service team-based care facility which provides urgent, non-emergency 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 as capacity opens within a broader PCN. The establishment of UPCCs offers extended hours for the general population, and increased attachment for under-served populations.
- CHCs are multi-sectoral health and social service organizations, providing a community population with primary health care. People served by CHCs is typically geographically defined, although a CHC may target their services to a community of specialized need residing across multiple geographical areas. CHCs are either community governed or community informed, with services tailored to meet the health needs of the community. CHCs also prioritize the attachment of hard-to-reach, vulnerable, and under-served populations, and are a key resource in helping to address social determinants of health through linkages to community agencies.
- FNPCCs are primary health care clinics developed in collaboration with the First Nations Health Authority that deliver team-based culturally safe primary health care, as well as improving 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 service model developed by NPs who will work within a collaborative, team-based environment, both within the practice and as part of the local PCN. They are an innovative solution to support communities where a large part of the population has difficulty accessing a regular primary care provider.

## FINANCIAL IMPLICATIONS

*Budget 2021* includes $253M over 3 years ($63M; $95M; $95M) to continue to expand team-based and urgent primary care. This builds on funding allocated in *Budget 2018* to support recruitment of primary care health professionals for team-based care (including additional GPs and NPs) and to pilot innovation hubs. *Budget 2018* year-3 allocation of $153M continues as part of the Ministry's base budget ($458M over 3 years). Total net new funding for the Primary Care Strategy is $711M over 3 years ($215M/ $248M; $248M).

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**Approved:**

February 5, 2021 - Shana Ooms obo Ted Patterson, ADM Primary Care Division
February 12, 2021 - Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
May 13, 2021 - Kerri Harrison, obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Urgent and Primary Care Centres

### TOPIC

In 2018/19, the Ministry of Health launched a transformational team-based primary care strategy, envisioned to increase patient attachment and access to quality, comprehensive, culturally safe, person-centred primary care services across the province, and will be delivered using several different service models including Urgent Primary Care Centres (UPCCs). UPCCs provide a flexible resource to meet both the urgent unplanned and ongoing planned primary care needs of people in communities. UPCCs fulfill service gaps in communities and provide urgent, non-emergency primary care to people within 12-24 hours. UPCCs also provide temporary and/or ongoing attachment to patients who do not currently have a regular care provider and facilitate attachment to the UPCC or to other providers within a PCN.

### CURRENT SITUATION

- Government committed to establishing 30 UPCCs across the province by December 2021. Further expansion of additional UPCCs/CHCs has recently been approved, and as a result, 10 more UPCCs/CHCs are expected to be implemented over the next 3 years.
- As of March 3, 2021 the Ministry announced 24 UPCCs, 21 of which are operational, with another 9 in planning. UPCC locations were selected based on a number of factors including review of data such as emergency department utilization, patient access and attachment rates.
- UPCCs have been self-reporting since November 2018. However, many UPCCs served as interim COVID-19 assessment centres which paused reporting between March and May 2020, with many continuing to provide COVID-19 assessment and testing throughout spring/summer 2020 and into fall/winter 2020/21.
- As of March 3, 2021 UPCCs have provided over 678,799 patient visits[1].

### KEY FACTS[2]

- UPCCs provide expanded hours to improve access to same-day non-emergency health care, increase existing primary care capacity, and reduce pressures on emergency departments. UPCCs provide a mix of both urgent and longitudinal primary care appointments, with an emphasis on enabling new patient attachment and prioritizing attachment for local populations that are considered under-served or vulnerable.[3] UPCCs provide coordination and continuity of care, linked to the broader network of primary care providers and inter-disciplinary teams through Primary Care Networks (PCNs). When possible, UPCCs use alternate compensation models rather than traditional fee-for-service to support team-based care.
- UPCCs reflect different business models. While mainly health authority owned and operated, some early sites are operated together with a local service provider. All are planned in partnership with local Divisions of Family Practice. 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 increased access via extended hours. In 2019 UPCC policy was updated to include onsite attachment.

**Fraser Health Authority's UPCCs**

- North Surrey UPCC, focused on urgent access only, opened on November 8, 2018. As of March 3, 2021- 62,217 patient visits; attached 1,284 patients.
- Burnaby Edmonds UPCC, focused on urgent access only, opened September 23, 2019 at the PrimeCare Medical Centre, evening/weekend access to team-based care. As of March 3, 2021, along with the Central Park Satellite UPCC (COVID-19) - 83,659 118,450 patient visits; attached 766 patients.
- Ridge Meadows UPCC, Phase 1 opened in a temporary location on October 1, 2019, and Phase 2 opened on September 30, 2020, with a co-located PCN Wellness Centre at its permanent location in Haney Place Mall, Maple Ridge. As of March 3, 2021 - 18,748 patient visits; attached 658 patients.
- Surrey Newton UPCC, opened on May 25, 2020 with urgent care services on evenings and weekends. Longitudinal services and extended hours started September 14, 2020. As of March 3, 2021 - 7,129 patient

[1] All volume and patient visits data are self-reported regional health authority reporting. Results Management Office, PCD (December 2020).
[2] Ibid.
[3] See Supportive Policy Directive, Urgent and Primary Care Centres (revised October 2019).

visits; attached 243 patients.

- Abbotsford UPCC opened on April 17, 2020 as a COVID-19 assessment site and transitioned to a UPCC on April 24, 2020. Longitudinal services started June 22, 2020. As of March 3, 2021 - 12,844 patient visits; attached 506 patients.
- Port Moody UPCC, focused on urgent access only, opened on February 22, 2021. As of March 3, 2021, the UPCC has had 25 patients visits and attached one patient.

**Interior Health Authority's UPCCs**

- Kamloops Urgent Care Clinic and the Family Practice Learning Centre (FPLC), opened on June 12, 2018 and August 27, 2018, respectively. As of March 3, 2021, the UPCC and FPLC had a combined patient visit total of 55,827 and attached 1,196 patients to the FPLC.
- Kelowna UPCC, focused on urgent access only, opened on December 30, 2019. As of March 3, 2021 - 41, 298 patient visits.
- Vernon UPCC, opened a temporary location on October 1, 2019, and began operations from its permanent location March 31, 2020. As of March 3, 2021 - 23, 964 patient visits; attached 384 patients.
- Castlegar UPCC, focused on urgent access only, opened April 6, 2020. As of March 3, 2021 - 4,228 patient visits.
- West Kelowna UPCC, focused on urgent care access only, opened on October 1, 2020. As of March 3, 2021 - 7,808 patient visits.

**Vancouver Coastal Health Authority's UPCCs**

- Vancouver City Centre UPCC, which is focused on urgent access only, is a partnership between Vancouver Coastal Health and Seymour Health. It opened on November 26, 2018. As of March 3, 2021 - 67,071 patient visits with 2,969 patients attached via referrals to their adjacent Patient Medical Home.
- North Vancouver UPCC, focused on urgent access only, opened on November 4, 2019 and is also a partnership with Seymour Health. As of March 3, 2021 - 40,079 patient visits.
- REACH UPCC in East Vancouver, focused on urgent access only, opened on November 4, 2019 in a temporary location and moved into its permanent location on February 29, 2020. As of March 3, 2021 - 16,990 20,551 patient visits.
- Vancouver Northeast, focused on urgent access only, opened on February 16, 2021. As of March 3, 2021, the UPCC has seen 273 patient visits.
- Northern Health Authority's UPCCs:
- Quesnel UPCC, focused on urgent access only, opened on October 31, 2018. As of March 3, 2021 - 13,636 patient visits; attached 1 patient.
- Prince George UPCC initially focused on urgent access, opened on June 5, 2019. As of March 3, 2021- 50,053 patient visits; attached 225 patients.

**Vancouver Island Health Authority's UPCCs**

- Westshore UPCC (South Island), focused on urgent access only, opened on November 5, 2018. The UPCC is co-located with a primary care pod and the CARES Mental Health and Substance Use Clinic. As of March 3, 2021 - 62,300 patient visits; attached 1,790 patients.
- Medical Arts UPCC in Nanaimo, focused on urgent access only, opened on September 3, 2019 and is a partnership with the Medical Arts Centre. As of March 3, 2021 - 52,464 patient visits; attached 1,322.
- James Bay UPCC in Victoria opened April 28, 2020. As of March 3, 2021 - 19,836 patient visits; attached 2,236 patients.
- North Quadra UPCC in Victoria opened on November 30, 2020. As of March 3, 2021, the UPCC has seen 2,786 patients visits; attached 196 patients.

## FINANCIAL IMPLICATIONS

The estimated annual operating costs for 20 of the 22 UPCCs is $67M (estimated costs for for Penticton and Port Moody UPCCs are not yet finalized). Across all 22 UPCCs, 17 have required capital funding, consisting of $22.2M from the Ministry, $5.8M from health authority internal sources, $7.1M from regional hospital districts, and $0.95 from Landlords. *Budget 2021* announced (as part of the $253M) an incremental $90M in operating funding over 3 years ($30M/ $30M/ $30M) to expand the number of UPCCs across the province to 40 (an increase of 10 UPCCs).

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
February 19, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
May 14, 2021 – Kerri Harrison obo Philip Twyford, ADM, Finance and Corporate Services Division
June 10, 2021 – Ted Patterson, ADM, Primary Care Division

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# LEGISLATIVE SESSION - FACT SHEET

## Academic Health Science Network

### TOPIC

- The BC Academic Health Science Network (AHSN) was established in February 2016, to support health system transformation through translation and application of research and scaling and spreading this in priority areas essentially, a "learning health system".
- Trials BC, Research Ethics BC (REBC) and the BC SUPPORT Unit, a multi-partner organization created to support, streamline and increase patient-oriented research throughout BC.

### CURRENT SITUATION

- The AHSN is supporting several COVID-19 related activities including: improved ethics harmonization and clinical trial support, funding for the health data platform (the COVID data library), research and survey inventories that are regularly being updated and planning support for the Post COVID-19 Integrated Clinical Care Network.

Advice/Recommentations

### KEY FACTS

- The AHSN was established in 2016 under the *Society Act* with an independent nine-member Board.
- The AHSN consists of three operational units that form the backbone of the organization: the BC SUPPORT Unit, Clinical Trials BC, and REBC. Together, they deliver a range of essential knowledge management services and supports that collectively enable Learning Health Systems in BC and strengthen reach and impact.
- Clinical Trials BC advances BC's development as a world-class destination for clinical trials across the province's hospitals, research institutions and communities. Clinical Trials BC's mission is to maximize the health, educational, and economic benefits of clinical trials to the citizens of BC.
- REBC works to make BC a more competitive and innovative health research environment by streamlining and improving research ethics review processes. REBC supports a provincial, harmonized system for research ethics reviews of multi-jurisdictional studies involving human subjects (i.e. involving the resources, people, patients or data from more than one BC institution). It' s founded on a collaborative effort by a group of BC health research partners to develop the harmonized ethics review models now in use by most BC health authorities and research universities.
- Established through the Canadian Institutes for Health Research, the Strategy for Patient Oriented Research (SPOR), BC SUPPORT Unit represents a major funding commitment from the federal and provincial government.
- The BC SUPPORT Unit has 2 main roles: 1) providing services to researchers, patients, health care providers and health system decision makers; and 2) facilitating initiatives identified as provincial priorities. Its purpose is to make the conduct of high quality, relevant research in BC much easier.
- The AHSN has received and is receiving Ministry funding to establish the evidence-informed Long Term Care Quality Improvement Initiative. This project supports quality improvement in long-term care facilities and supports initiatives to attract and retain health care aides and licensed practical nurses in LTC. It also supports health sector planning and responses to LTC lessons learned during wave 1 of COVID-19.
- Dr. Stirling Bryan is the President of the organization as of January 1, 2020. He replaces Dr. Tom Noseworthy as the organization's inaugural leader; Mary Ackenhusen, Senior Executive in Residence, currently participates on the AHSN Board as the Ministry's representative.

- To support the provincial response to COVID-19, the AHSN is currently:
    - hosting and updating daily the BC COVID-19 Research Inventory which includes all currently funded COVID-19 related projects in BC;
    - hosting and updating the BC COVID-19 Survey Inventory which COVID-19 surveys with a BC component;
    - supporting a rapid ethical review process for provincial clinical COVID-19 research to increase the speed at which clinical research can get underway through the REBC unit;
    - providing clinical trials training, regulatory consulting, and a COVID-19 network to support researchers engaged in COVID-19-related clinical trials through the Clinical Trials BC unit;
    - facilitating patient and public input to the COVID-19 Strategic Research Advisory Committee's adaptive research framework (version 2);
    - providing coordination support to a University of British Columbia/Providence clinical care- research initiative described below; and
    - enabling patients to be matched with relevant COVID-19 research opportunities through REACH BC, a demonstration project of the BC SUPPORT Unit.

## FINANCIAL IMPLICATIONS

- Total funding for the BC SUPPORT Unit is $79.9 million over 5 years, including $39.9 million from the Government of Canada and $39.9 million from the Government of BC[1]. The Ministry's portion of the provincial funding is $8.9 million over 5 years. The funding agreement ends in March 31, 2021.
- The AHSN submitted a business plan for SPOR BC SUPPORT Unit Phase 2 in November, 2020, which included a funding request of $12 to 16 million from the Ministry. Phase 2 would run from 2021 to 2025.
- The Ministry provided the AHSN Society $2 million in 2017/18, $3.955 million in 2018/19 and $2 million in 2019/20 to further operations and activities. This funding is separate from the $8.9 million funding commitment.
- Going forward, MSFHR and AHSN will submit a coordinated funding request to the Ministry.

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**Approved:**
January 27, 2021 – Victoria Schuckel, Partnerships and Innovation Division
February 3, 2021 – Ian Rongve, ADM, Covid Response and Health Emergency Management Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] https://news.gov.bc.ca/releases/2016HLTH0080-002321

# LEGISLATIVE SESSION - FACT SHEET

## Agencies, Boards, and Commissions Appointments

### TOPIC

Agencies, Boards, and Commissions (ABCs) recruitment, selection and appointment process is the joint responsibility of the Ministry of Health (the Ministry) and Crown Agencies and Board Resourcing Office (CABRO). The collaborative process ensures governing ABCs have the necessary expertise and membership.

### CURRENT SITUATION

The Ministry is communicating with the various boards and working with CABRO to address upcoming vacancies, appointees' willingness to be considered for reappointment, and possible candidates for appointment consideration.

### KEY FACTS

- The Ministry is responsible for facilitating the appointment of approximately 315 public members, for about 42 ABCs serving the health sector.
- ABCs include the 6 health authority boards, 18 professional college boards, the Emergency Medical Assistants Licensing Board, the Medical Services Commission, the Drug Benefit Council, the Data Stewardship Committee, the BC Patient Safety and Quality Council, the BC Health Care Occupational Health and Safety Society, the Health Care Practitioners Special Committee for Audit Hearings and 6 Patient Care Quality Review Boards.
- There will be approximately 130 appointments required by December 31, 2021, and there are currently 29 vacancies across 10 ABCs. Some ABCs have multiple vacancies and challenges include ensuring quorum and board constitution requirements in legislation are met.
- CABRO and the Ministry handle the process for the recruitment, appointment and orientation of board members to ensure that governing ABCs have the necessary expertise and membership.
- In order to address diversity, all boards aim to have balanced gender, Indigenous, ethnic and geographical representation.
- Good governance and strong leadership by ABCs across the health sector is critical to ensuring continued excellence in the BC health system and accountability to the citizens of the province.

Background

- In 2017, the Board Resourcing and Development Office merged with the Crown Agency Resource Office to become CABRO and Cabinet delegated greater responsibility to the Ministries. Since that time, a refreshed process for board appointments has been introduced, with CABRO taking a leadership role and directly communicating with the Minister’s Office.
- CABRO and the Ministry are jointly responsible for managing the overall appointment process, including identifying (recruiting) and determining the eligibility of new candidates, and securing the Minister’s approval. Recruitment of board members is the joint responsibility of the Minister, CABRO, program areas, and boards. The Minister provides the strategic direction. Gender, Indigenous and ethnic representation are key considerations for appointments.

### FINANCIAL IMPLICATIONS

N/A

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**Approved:**
January 27, 2021 – Victoria Schuckel, Partnerships and Innovation Division

# LEGISLATIVE SESSION - FACT SHEET

# Federal Funding - Bilateral Agreement

## TOPIC

Status of the *Canada-British Columbia Home and Community Care (HCC) and Mental Health and Addictions (MH&A) Services Funding Agreement (Bilateral Agreement)*.

## CURRENT SITUATION

- Fiscal year 2020/21 is year four of the Bilateral Agreement. Over the 4-year period, BC has received a total of $471.49 million ($282.74 million for HCC and $188.75 million for MH&A).
- The federal government's Fall Economic Statement 2020 proposed "Up to $1 billion to establish a Safe Long-term Care Fund to help provinces and territories protect people in long-term care and support infection prevention and control."[1]Intergovernmental Communications

Intergovernmental Communications

## KEY FACTS

- Federal funding for health care is primarily provided through the Canada Health Transfer (CHT).
- Since 2017, the CHT growth rate/escalator has been based on GDP growth (with a floor of 3%).
- Currently, the federal government's contributions through the CHT make up approximately 23% of provincial and territorial health spending nationally (23.1% in 2018/19 in BC).
- In 2020/21, the CHT will total $41.87 billion nationally, of which BC's share is expected to be approximately $5.67 billion[2].
- In addition to the CHT, in 2017 the federal government committed to provide BC with $1,487.35 million in targeted funds over 10 years (2017/18 through 2026/27), BC's per capita share, in two areas:
    - $810.99 million for home and community care; and
    - $676.36 million for mental health and addictions services.[3]
- Federal funding for 2017-18 to 2021-22 will be in accordance with the *Canada-British Columbia Home and Community Care and Mental Health and Addictions Services Funding Agreement* that was signed by BC's Minister of Health and the federal Minister of Health on August 21, 2018. Funding for the remainder of the 10-year commitment will be provided upon renewal of the Bilateral Agreement for a second 5-year term.
- The 2018/19 to 2021/22 Bilateral Agreement and accompanying action plan specify how BC will use the federal funding in alignment with the *Common Statement of Principles on Shared Health Priorities,* which was released with agreement from all Federal, Provincial and Territorial (FPT) Health Ministers on August 21, 2017.[4]
- The table below highlights action plan initiatives partially supported with Bilateral Agreement funding.

[1] https://www.budget.gc.ca/fes-eea/2020/themes/fighting-covid-19-lutter-contre-covid-19-en.html

[2] Federal Department of Finance website: https://www.canada.ca/en/department-finance/programs/federal-transfers/major-federal-transfers.html#BritishColumbia

[3] Based on Health Canada November 9, 2020 update.

[4] *Canada-British Columbia Home and Community Care and Mental Health and Addictions Services Funding Agreement* and Health Canada website: https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/principles-shared-health-priorities.html

# LEGISLATIVE SESSION - FACT SHEET

| Home and Community Care | Mental Health and Addition Services |
|---|---|
| • Develop regional Specialized Community Services Programs, which will integrate services needed by adults and seniors with complex medical conditions and frailty, including palliative care. These programs will be integrated with Primary Care Networks to identify at-risk clients and address their specialized care needs. Services include expanded access to home support services, optimizing the role of community-based professional services, and increased supports for caregivers.<br>• Expand access to 24/7 community-based palliative and end-of-life care services by increasing resources to meet client needs; increasing investments in education and training for care providers; increasing generalist clinicians' access to expert consultation for pain and symptom management, and ensuring that clients returning to the community post-hospitalization have neeeded supports.<br>• Leverage technology and infrastructure to improve access to care (e.g., expanding the provincial Home Health Monitoring Program to support chronic disease management); improve multidisciplinary teams' communications; and increase the availability of mobility equipment to reduce barriers to hospital discharge.<br>• Strengthen the linkages between health authorities and community-based NGO services to support seniors living in the community with complex, and chronic health challenges, and for those who are at risk of frailty. | • Implement a series of early action initiatives designed to take immediate action to address the most pressing service gaps and pave the way for BC's new mental health and addictions strategy. A new and integrated telehealth service will be implemented, focusing on preventing and intervening early with childhood anxiety.<br>• Develop up to 11 integrated youth services centres across the province, and develop a virtual workforce designed to provide access through a virtual clinic access point, eFoundry.<br>• Increase access for students to mental health and addiction prevention services to respond to the diversity of students across the province, including Indigenous, LGBTQ2S, immigrant, refugee, and newcomer student communities.<br>• Significantly expand access to culturally safer and trauma-informed mental health and addiction services for Indigenous communities through a focused approach to suicide, crisis intervention and land-based healing opportunities. This holistic approach to individual and family healing includes culturally based assessment and programming, trauma-specific services, case management, treatment services, and appropriate follow-up/referrals, aftercare, and ongoing monitoring.<br>• Expand access to evidence-based treatment and recovery options for vulnerable populations. |

## FINANCIAL IMPLICATIONS

- As reflected in BC's 2019/20 Annual Financial Statement (submitted to Health Canada on September 29, 2020), BC has not carried over any unexpended funds into the next fiscal year.
- Subject to annual adjustment based on yearly population estimates, with funding 2022/23 through 2026/27 being contingent upon renewal of the Bilateral Agreement for an additional 5-year term, BC's federal funding amounts were/will be:

| Fiscal Year | Home and Community Care ($ Millions) | Mental Health and Addictions ($ Millions) |
|---|---|---|
| *Actual Funding Received* | | |
| 2017-18 | 26.19 | 13.09 |
| 2018-19 | 80.82 | 33.67 |
| 2019-20 | 87.69 | 60.71 |
| 2020-21 | 88.04 | 81.27 |
| *Estimated Funding Amounts for Future Years (subject to annual adjustment*)* | | |
| 2021-22 | 121.90 | 81.27 |
| 2022-23 | 81.27 | 81.27 |
| 2023-24 | 81.27 | 81.27 |
| 2024-25 | 81.27 | 81.27 |
| 2025-26 | 81.27 | 81.27 |
| 2026-27 | 81.27 | 81.27 |
| Total | 810.99 | 676.36 |

*Amounts are Health Canada calculations, based on population estimates.

**Approved:**
February 1, 2021 – Victoria Schuckel, Partnerships and Innovation Division
February 15, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Genome BC

## TOPIC

Genome BC is an independent not-for-profit organization that serves as the catalyst and funder for genomics research and applications in BC.

## CURRENT SITUATION

Genome BC is currently starting the first year of its 2020-2023 strategic plan: "Genomics positively impacts life, everyday". The plan reflects a total investment portfolio of $193 million for 2020 to 2023. As one of six Genome Canada centres, Genome BC receives approximately 26% of its funding from Genome Canada. The remainder of the co-funding is secured from the private sector or other organizations (52%) and the Province of BC (22%).

## KEY FACTS

- Genome BC is one of six regional centres established by Genome Canada in 2000/01 to coordinate the development of genome sciences in Canada. It is governed by an independent board with representatives from universities and the private sector. Mary Ackenhusen, Executive in Residence at the Ministry of Health, sits as a government observer.
- The majority of Genome BC research funding supports health research (50%+) and technology platforms that support all sectors (17<20%). The remaining research funding supports contributions to forestry (11%), fish and fisheries, (7%), agriculture (6%), mining/energy (4%), and environment (2%). Projects span the entire continuum from discovery research through to commercialization, with an increasing focus in recent years on translation and commercialization.
- BC has emerged as a leader in genomic health research nationally and internationally. This has positioned BC well for application of genomics in the emerging field of precision or personalized medicine, in which variation in the human genome can be linked to a patient's susceptibility to disease or response to treatment, allowing for earlier and more nuanced diagnosis, more accurate prognosis, and delivery of treatment strategies tailored to the characteristic of the individual patient. Jurisdictions around the world are recognizing the potential of personalized medicine for transforming health care and as a foundation for economic growth.
- Genome BC and the Michael Smith Foundation for Health Research collaborate closely and provide complementary support for current platforms (proteomics, genomics and bio-banking) and other programs.
- A three-year rolling accountability cycle with government ensures there are yearly service plans with performance measures and targets, and an annual performance report to government. This is meant to enable clear communication, coordination and accountability across government and with the organization. The next accountability cycle begins in the 2020/21 fiscal year.
- Pascal Spothelfer is the CEO of Genome BC. John F.H. Thompson is Board Chair.

## FINANCIAL IMPLICATIONS

- Since 2001, the Province has contributed $287.78 million (including $29 million provided by the Ministry in March 2019) to support Genome BC. Of this total amount, the Ministry has contributed $140 million.
- To support COVID-19 research, Genome launched the COVID-19 Rapid Response Fund for research projects up to $250,000. Funded by internal resources, there are thirteen projects underway totaling $1.78 million. An additional $250,000 from Genome Canada is supporting the *SARS-CoV-2 Sero-Epidemiological Study of Workers in British Columbia* with the goal of establishing and implementing workplace best practices for relaxing restrictions, while limiting infection and managing positive cases.

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**Approved:**

January 27, 2021 – Victoria Schuckel, Partnerships and Innovation Division
February 3, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Health Technology Assessment (Non-Drug)

### TOPIC

- Health Technology Assessment (Non-Drug) is an evidence-informed decision-making process for assessing which new or existing health technologies (devices, diagnostics, and procedures) should be publicly funded across the province (not including pharmaceuticals).
- Evidence-informed decisions ensure the citizens of BC receive the best health care the province can afford.

### CURRENT SITUATION

- The Health Technology Assessment (HTA) process is an annual, continuous process.
- The HTA Committee is now prioritizing which technologies will be assessed in the 2021/22 fiscal year, while continuing to complete work on topics that were assessed in previous years.

### KEY FACTS

- In 2011 the Ministry and the six provincial health authorities signed a Memorandum of Understanding establishing the HTA process. The objective of the process is to ensure the use of ineffective, wasteful technology is minimized and effective technology that provides value for money is diffused into the system.
- The HTA Committee is comprised of high-level representatives from each health authority and the Ministry, as well as a representative of Provincial Health Services Authority Supply Chain, a social epidemiologist, an ethicist, an economist, and two public members, all with equal voting privileges.
- The Ministry's HTA Office provides leadership, coordination and policy support to the Committee.
- Assessments analyze the evidence behind a technology and the underlying medical condition to produce recommendations regarding the introduction, expansion, restriction, or removal of health technologies.
- The assessment process includes systematic reviews of the existing clinical evidence, expected budgetary impact, clinician and patient perspectives, a jurisdictional scan, and other implementation or disinvestment considerations.
- Final funding decisions are made by a committee of senior health system executives based on the recommendations of the HTA Committee.
- The Ministry also provides funding to the Canadian Agency for Drugs and Technologies in Health (CADTH) to provide rapid evidence reviews that support local decision-making for technologies not prioritized in the HTA process. CADTH is jointly funded by the provinces and the federal government.
- Recent HTAs have been conducted on: implantable cardiac monitors, DNA Mismatch Repair testing, the use of neuromodulation for cancer and non-cancer pain, polypropylene surgical mesh, computed tomography for pulmonary embolism, deep brain stimulation for advanced Parkinson's disease, and ceramic hip implants.
- Provincial health technology assessment processes are also in place in Alberta, Ontario and Quebec.
- Prescription drugs continue to be assessed through the BC Drug Review Process, while the BC Agency for Pathology and Laboratory Medicine has a separate process to assess lab tests.

### FINANCIAL IMPLICATIONS

- The budget for health technology (non-drug and non-information technology) assessment activities in the province is approximately $1.868 million for 2020/21 ($1.400 million for Ministry contracts and $468,284 in CADTH funding).[1] This figure does not include Ministry staff salaries.
- $1 million of the current budget is provided by the regional health authorities ($200,000 from each regional health authority).

[1] This figure reflects expenditures on provincially coordinated activities and does not include any expenditure associated with local health technology assessment that may occur in individual hospitals or health authorities. $400,000 is dedicated to economic analyses of health technologies from funds supporting implementation of *Putting Our Minds Together*.

# LEGISLATIVE SESSION - FACT SHEET

**Approved:**
January 18, 2021 – Victoria Schuckel, Partnerships and Innovation Division
January 29, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Michael Smith Foundation for Health Research

### TOPIC

The Michael Smith Foundation for Health Research (MSFHR) is the province's health research funding organization with a provincial mandate to: i) facilitate and support the development of health research in BC; and ii) encourage the application of research results for the benefit of British Columbians.

### CURRENT SITUATION

- MSFHR is beginning the first year of its 2020 – 2025 Strategic Plan. New elements of this plan include enhanced access to funding for non-traditional researchers (those working outside of academic settings) and researchers in geographically dispersed areas. MSFHR will report annually on activities that support equity, diversity, and inclusion in the health research system.
- MSFHR is actively supporting BC's coordinated provincial COVID-19 research response (see Provincially Coordinated COVID-19 Research Response Fact Sheet).

### KEY FACTS

- MSFHR was established as an independent society under the *Society Act* in 2001. It is governed by a board of directors with representatives from universities, health authorities, non-profit organizations, and the business community. The organization's funding provides salary support for health researchers and researchers-in-training, across all 4 pillars of health research (biomedical, clinical, health services/policy and population health) and supports health sector priority projects (e.g., . Health Authority Capacity Building, health professional research programs).
- MSFHR and Genome BC collaborate closely to complement and not duplicate investments. A three-year rolling accountability cycle ensures there are yearly service plans with performance measures and targets and an annual performance report to government. This is meant to enable clear communication, coordination and accountability across government and with the organization. The next accountability cycle begins in the 2020/21 fiscal year.
- Bev Holmes, PhD, is President and CEO of MSFHR. Dr. Elinor Wilson is Board Chair. Mary Ackenhusen, Senior Executive Lead, sits on the board on behalf of government.

### FINANCIAL IMPLICATIONS

Since 2001, the Province has provided approximately $529.59 million to the MSFHR to support its mandate as well as targeted programs (including $60 million provided by the Ministry in 2018/19). The total funding includes $2 million provided by the Provincial Health Services Authority to MSFHR in 2019/20 to support a coordinated provincial research response to COVID-19.

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**Approved:**

February 1, 2021 – Victoria Schuckel, Partnerships and Innovation Division
February 2, 2021 – Ian Rongve, ADM, Covid Response and Heath Emergency Management Division
February 7, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Population Experience Survey of Primary Care

### TOPIC

- The Ministry / Providence Health Care through the Office of Patient Centred Measurement is developing a BC Population Experience Survey of Primary Care (BCPES-PC). Survey development has been guided by a Primary Care Survey Consultation Group (CG), first convened in August 2019.
- All British Columbians enrolled in MSP will be eligible to be surveyed.
- The BCPES-PC will gather perspectives on access and how well the primary care system is meeting the needs of British Columbians. The survey will:
  1. Provide information from the patient perspective to inform system accountability and evaluation, and where possible, to promote community-level quality improvement;
  2. Pilot an approach to increasing representation of people who have historically not participated in surveys and who may be experiencing barriers to care due to multiple intersecting determinants of health; and
  3. Measure how Primary Care Networks (PCNs) are impacting patient reported quality of care by comparing current state, changes/ trends over time, and PCN- versus non-PCN communities.

### CURRENT SITUATION

- Target date for fielding the survey is April 2021.
- The survey is comprised of 87 questions, respondents will be asked a sub-set of these questions depending on whether they have recently accessed care or not (on average patients will complete 60 questions).
- The survey questions have been tested with representative respondents (individuals and groups selected to reflect the target populations from across BC). Questions are being revised based on respondent feedback.
- Issues related to implementation, including sample planning, are currently being considered.

### KEY FACTS

- Other sector surveys in the BC health care system have collected patient assessments of the quality of their care as a provincially coordinated initiative since 2002 (e.g., Emergency Department, Acute Care and Long-Term Care); this is the first province-wide survey for the Primary Care sector.
- A Primary Care survey has been contemplated by the Primary Care Division and the Office of Patient Centred Measurement for many years, and was identified as a critical support for the roll-out of new Primary Care models, including the PCNs.
- The BCPES-PC builds on Alberta's provincial primary care survey, which was selected as the core survey instrument following a literature review of existing tools and endorsement by the CG.
- The BCPES-PC was augmented with additional content identified by the CG to better meet British Columbia's information needs related to key areas identified as gaps in the core tool. Five Task Groups were convened from March to July 2020 to recommend themes for questions related to the topics below from the patient perspective:
  1. Attachment, Access, Communication;
  2. Cultural Safety (Indigenous Advisory Committee);
  3. Equity and Marginalised Groups ;
  4. Team-Based Care and Transitions ; and
  5. Family Caregiving
- The BCPES-PC was further tailored with additional content related to:
  - Emerging topics: Virtually enabled care module and perceived barriers to access related to COVID-19; and
  - Veteran's Rand 12-item Health Survey (VR12) Patient Reported Outcomes Measures questions measuring physical, mental and social health outcomes. VR12 is a validated outcomes tool and has been included in all sector surveys, where appropriate, since 2016.
- Respondents to the survey are asked to consider primary care experiences over the prior 6 months, with a focus on experiences during their most recent visit (either in-person or virtually).

- The Client Roster will be the source of respondent contact information. Medical Services Plan data will serve as a source from which to sample/oversample people who used care. Respondents will have a universal identifier linked to the respondent and non-respondent population that will permit linkage to other clinical and administrative databases for secondary analysis.
- In addition to CG and Task Group members, there has been ongoing consultation with stakeholders within and outside the Ministry. This consultation ensures the content of the survey is aligned with PCN attributes, sample plans and reporting levels.
- The Primary and Community Care Research Advisory Committee has received regular status updates and has been invited to provide input and feedback.
- The first cycle of the BCPES-PC will be funded through the annual operating budget of the Patient Centred Measurement Steering Committee (which comes off the top of the health authority annual budgets) and one-time funding support through the BC SUPPORT Unit's PCM Strategy for Patient Oriented Research program. The cost of the survey based on Local Health Area reporting will be determined by factors, such as number of questions, modes of delivery, etc., which are still being finalised. The survey is targeting 20,000 completions for each of BC's 89 Local Health Areas.

## FINANCIAL IMPLICATIONS

The cost for the 2021/22 survey is projected to be between $300,000 to $445,000. The Ministry is in the process of finalizing a vendor for this survey.

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**Approved:**

February 11, 2021 – Victoria Schuckel, Partnerships and Innovation Division
March 4, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
March 5, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

## Provincially Coordinated COVID-19 Research Response

### TOPIC

BC is seeking to ensure provincial COVID-19 research projects and infrastructure are well coordinated to maximize the benefit British Columbians derive from provincial and federal investments.

### CURRENT SITUATION

- Currently there are over 600 COVID-19 research projects underway in BC generating evidence related to biomedical, clinical, health services and policy and population health/public health areas relevant to BC.[1] There are also 120+ COVID-19 surveys that have collected or are collecting perspectives from British Columbians.[2]
- The need for strategic coordination of the breadth and volume of research was recognized early. Provincially, the Michael Smith Foundation for Health Research (MSFHR) and the BC Centre for Disease Control (BCCDC) are co-chairing a COVID-19 Provincial Strategic Research Advisory Committee (SRAC), to understand the needs of the province and to identify gaps in research (e.g., specific issues within long term care).[3]
- The SRAC reports to Stephen Brown, Deputy Minister; Dr. Bonnie Henry, Provincial Health Officer (PHO); and Ian Rongve, Assistant Deputy Minister. It includes a range of advisors, including Dr. Perry Kendall, former PHO; a Chief Medical Health Officer, a key provincial ethics advisor on COVID and patients, rural medicine physician, researchers, and health authority research leads. Three COVID research task groups related to vaccine, long term care and school-based issues have been struck by SRAC to further explore Academic Health Sciences Network (AHSN) research priorities.

### KEY FACTS

- The MSFHR is supporting COVID-19 related research funding and infrastructure in BC. The MSFHR COVID-19 Research Response Fund granted 20 awards to BC researchers. The organization also invested in administrative support to stand up the SRAC and used internal resources to support 4 COVID-19 Rapid Response Projects early in the pandemic. MSFHR is partnering with CIHR and other funders on research important to BC and is providing additional supports to enable COVID-19 clinical trial participation in all health regions. MSFHR also used internal resources to health authorities (HAs) to support COVID-19 clinical trial and research infrastructure through their HA Capacity Building Program.
- Genome BC launched its COVID-19 Rapid Response Fund early in the pandemic. 24 projects are currently underway. Genome BC also leveraged funding to BC from Genome Canada.
- The BC Academic Health Sciences Network Advice/Recommentations has supported expedited streamlined ethics approvals (Research Ethics BC), enhanced supports for clinical trials (Clinical Trials BC), and has provided mechanisms to engage patients in studies (BC Strategy for Patient Oriented Research SUPPORT Unit- and their project, REACH which provides a means for the public to engage in research projects). In addition to hosting the research and survey inventories, the organization has played an important role in connecting and supporting key COVID-19 research initiatives.
- The Ministry has used its Research and Knowledge Management Research Fund to support COVID-19 research priorities. This includes:
    - Seed Grants to universities across the province addressing COVID-19 research projects important to the health system.
    - Support for direct participation of Indigenous researchers in unintended consequences and impacts research and analyses (The BCCDC has contributed $200K to support this initiative)
    - Research support for Post-COVID-19 Integrated Care Network research for patients in BC who are recovering from, and who may have long term effects associated with, COVID-19.
    - Long term care implementation science teams ($150K).

[1] https://bcahsn.ca/covid-19-response/covid-19-research-inventory/
[2] https://bcahsn.ca/wp-content/uploads/2020/09/COVID-19-Surveys-in-BC-and-Canada-September-2020.pdf
[3] https://www.msfhr.org/sites/default/files/SRAC%20Framework%20Issue2_dec4.pdf

- Evaluation of Virtual Care, Hospital at Home, and Primary Care ($250K).

Cabinet Confidences; Government Financial Information

## FINANCIAL IMPLICATIONS

- In total, approximately $58.7M from provincial ($34.4M) and federal ($24.3M) sources has been/ is being invested in BC research to support the response to the pandemic.
- The provincial research funding commitment of approximately $34.4M to support COVID-19 research is comprised of:
  - Ministry funding of $1.3M from the Research and Knowledge Management Research Fund to emergent COVID-19 research priorities;
  - MSFHR funding $4.6M in COVID-19 related research and infrastructure;
  - Genome BC commitment of $3M towards COVID-19 research funding;
  - AHSN allocation of approximately $500,000 to support COVID-19 related research; and

Cabinet Confidences; Government Financial Information

- The $24.3M in federal research funding is comprised of $1.4M from Genome Canada, and $22.9M from CIHR and partners. Two additional federal competitions that will be underway shortly will further increase research investment in BC.
- Since 2001, the Province has provided approximately $529.6M to MSFHR to support its mandate as well as targeted programs. This funding includes $2M provided by the PHSA to MSFHS in March 2020 to support a coordinated provincial research response to COVID-19.
- Since 2001, the Province has contributed $287.53M (including $29M provided by the Ministry in March 2019) to support Genome BC. Of this total amount, the Ministry has contributed $140M.
- The Ministry has provided BC Academic Health Science Network $7.96M from 2017/18 to 2019/20 for BC research initiatives.

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**Approved:**

March 1, 2021 – Victoria Schuckel, Partnership and Innovation Division
March 4, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
March 5, 2021 – Ian Ronge, ADM, COVID Response and Health Emergency Management Division

# FACT SHEET

# Research and Knowledge Management Strategy

## TOPIC

"Putting Our Minds Together: Research and Knowledge Management Strategy" (the Strategy) is a plan to strengthen the Ministry of Health's relationship with the health research community and to use research evidence in health care policy development, implementation and evaluation.

## CURRENT SITUATION

- Under the leadership of the Partnerships and Innovation Division (PID), the activities under the Strategy focus both inwards and outwards to support a climate *within* the Ministry that values and supports research use as well as strengthen long-term relationships with the *external* research community.
- PID is monitoring and assessing the implementation of the Strategy to ensure that activities are tracked over time and are continuing to demonstrate results in our public commitments and ensures we have an adequate understanding of how these activities are supporting access to and use of research evidence and collaboration with the research community.
- This monitoring and assessment plan will inform the broader value the Strategy has brought to the Ministry, the research community, and where we might be able to improve.

## KEY FACTS

- In response to Recommendation 35 in the Ombudsperson's report "Misfire: The 2012 Ministry of Health Employment Terminations and Related Matters," the Ministry developed the Strategy which identifies Ministry activities to repair existing gaps in evidence-informed programs, to prevent other gaps in the future and to strengthen the use of research evidence in Ministry policy and decision making across all program areas.
- The Strategy was submitted to the Office of the Ombudsperson on December 29, 2017 and publicly released by the Minister of Health on March 8, 2018.
- Highlights of the Strategy's implementation to date include:
    - Dr. Malcolm Maclure's 2-year term as inaugural Scholar in Residence at the Ministry to enable his work, beginning in November 2018, in developing the Healthwiser rapid-cycle evaluation capacity – this has recently concluded.
    - Signing of the first multi-year agreement with the Therapeutics Initiative in October 2017 (in place until March 2023) to support evidence-informed policy and drug listing decisions in the Pharmaceutical, Laboratory and Blood Services Division, and prescribing quality and safety in the province.
    - Establishment of the Evidence Service to meet the needs of Ministry staff for timely, high quality evidence syntheses, jurisdictional scans and other rapid reviews.
    - Development of the Primary and Community Care Research Initiative (PCCRI), with primary care stakeholders across the province (including patients, community members, clinicians and researchers), to develop and apply evidence in the implementation of integrated, team-based primary and community care in the province. The Advisory Committee is providing advice and guidance to three PCCRI research initiatives: evidence synthesis on primary care implementation (completed); population-based primary care patient survey and learning cycles (to go into the field in April 2021) to enable rapid assessment of key areas to inform PCC implementation activities.
    - The Ministry's onsite Health Innovation Hub, a collaborative workspace where researchers, health care partners and members of the public have space and resources to co-create evidence-informed policy opened in April 2019.
    - Launch of Research Links (HLTHresearch@gov.bc.ca), a single access point for the research community to connect with the Ministry.
    - Re-establishment of the Ministry Research Advisory Committee, with representation from all divisions to strengthen program and corporate understanding of research gaps and to plan and increase the use

of research evidence. A process for identifying and procuring Ministry research evidence gaps has been developed.

- Health System Impact and Mitacs Research Fellows (PhD and postdoctoral level) have been matched to the Ministry and the Ministry of Mental Health and Addictions to support evidence-informed policy and decision making across Ministry program areas for terms of 1-2 years (to date, 12 Fellows have been placed in the Ministries of Health and Mental Health and Addictions).

## FINANCIAL IMPLICATIONS

- The Ministry's PID oversees the Research, Evaluation and Knowledge Management Fund (REKMF) for evidence-informed policy and decision making supported by the Strategy. The Ministry has allocated up to $5.0 million for the REKMF annually.
- In 2019/20, approximately $2.3 million of the $5.0 million available from the REKMF was spent on strategic research projects identified by programs and endorsed by the Strategic Executive Team.
- In 2020/21, PID allocated approximately $1.3 million for research into COVID-19-related, strategic, and operational priorities and approximately $3.5 million for strategy implementation, including the Health Innovation Hub from the REKMF.

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**Approved:**
February 1, 2021 – Victoria Schuckel, Partnerships and Innovation DIvision
February 2, 2021 – Ian Rongve, ADM, Covid Response and Health Emergency Management Division
February 7, 2021 – Godon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

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# LEGISLATIVE SESSION - FACT SHEET

## Academic Detailing

### TOPIC

The BC Provincial Academic Detailing (PAD) service is an educational service that uses academic detailing to provide an objective and balanced view of drug evidence and drug information to support the optimal use of drugs by health professionals.

### CURRENT SITUATION

- The BC PAD service has 12 pharmacists (11.75 FTEs) who provide academic detailing to over 2,500 family practice physicians, pharmacists and other health care professionals for each therapeutic topic.
- Current topics are: Medications for insomnia and Antidepressants.
- Since the start of the COVID-19 pandemic, PAD sessions have been delivered virtually.

### KEY FACTS

- Academic detailing is an educational strategy in which a clinical pharmacist visits a physician or other health care professional in their practice setting to provide objective, balanced, evidence-informed drug information on the best prescribing practices.[1,2]
- Systematic reviews of academic detailing conclude academic detailing can effectively influence the prescribing practices of health care professionals and promote better patient health.[2,3]
- A number of stakeholders and advocacy groups support the role of academic detailing in health care, including the Auditor General, the Health Council of Canada, the Doctors of BC and BC health authorities.[3,4,5]
- Academic detailing is being utilized in 5 Canadian provinces: BC, Alberta, Saskatchewan, Ontario, and Nova Scotia. Internationally, academic detailing has been used in Australia, New Zealand, England, the Netherlands, and the US.[1]
- The BC Community Drug Utilization Program, the first academic detailing program in Canada, provided academic detailing services to 40 physicians associated with Lions Gate Hospital from 1993 to 2007.[1]
- The BC PAD service was launched in March 2008.[6]
- The goals of the service are: 1) to improve the health of British Columbians; 2) to provide high quality drug information to physicians and other health care professionals; 3) to encourage the use of therapeutically equivalent, cost effective drugs; 4) to evaluate the impact of academic detailing; and 5) to collaborate with academic detailing groups across Canada.
- Funding for the service is provided to regional health authorities for the pharmacists, support personnel and equipment.
- The pharmacists who deliver the service receive specialized training in academic detailing, attend topic-specific upskilling workshops and do extensive self-study prior to the launch of each topic.
- For each topic, a thorough review of the literature is conducted, and written materials are developed and peer-reviewed. Each topic is accredited for 1.0 Mainpro+ continuing medical education credits.
- To date, 19 topics have been launched:
    1. HPV vaccine;
    2. anticoagulation in atrial fibrillation;
    3. antibiotics in community practice;
    4. inhaled medications for chronic obstructive pulmonary disease;
    5. osteoporosis: focus on bisphosphonates;

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[1] Maclure M, Allen M, Bacovsky R, Bugden S, Lopatka H, MacNair K, Morrow R, Nguyen A, Regier L. Show Me the Evidence: Best practices for using educational visits to promote evidence-based prescribing. Victoria, BC: Drug Policy Futures; 2006.

[2] Sketris I, Ingram EL, Lummis H. Optimal Prescribing and Medication Use in Canada: Challenges and Opportunities. Toronto ON: Health Council of Canada; 2007.

[3] Health Council of Canada. Safe and Sound: Optimizing Prescribing Behaviours - Summary of Main Themes and Insights (Report on a Policy Symposium). Toronto, ON: Health Council; 2007.

[4] OAG of BC. Managing PharmaCare: Slow Progress Toward Cost-Effective Drug Use and a Sustainable Program. Victoria, BC: Ministry of Health; 2006.

[5] BC Medical Association. A Prescription for Quality: Improving Prescription Drug Policy in BC. Vancouver: British Columbia Medical Association; 2007.

[6] Province Promotes Best Practices for Drug Prescribing. Ministry of Health New Release, March 25, 2008: 2008HEALTH0028-000410.

6. statins and cardiovascular disease;
7. acute otitis media;
8. opioids in chronic non-cancer pain: the basics;
9. oral anticoagulants in atrial fibrillation: Update 2014;
10. proton pump inhibitors;
11. glucose lowering medications;
12. urinary tract infections in primary and long-term care;
13. COPD inhaled medications;
14. buprenorphine-naloxone for opioid use disorder;
15. hypertension in older adults: Blood pressure goals and medication choices;
16. medications for neuropathic pain;
17. Basal insulin for type 2 diabetes;
18. Antidepressants: Drug information; and
19. Medications for Insomnia.

- Continuous evaluation of the PAD service includes ongoing assessment of participant acceptance of the service. Survey results have demonstrated the academic detailing sessions are very well received by the over 2,500 physicians and over 1,000 other health care professionals who have participated in at least one session.
- An analysis of PAD's 'antibiotics in community practice' topic indicated physicians who met with the service's pharmacists were 2 to 6 times more likely to prescribe the recommended first-line antibiotic for acute sinusitis (Odds Ratio = 2.03), community-acquired pneumonia (Odds Ratio = 5.82), and urinary tract infections (Odds Ratio = 2.77), than physicians who do not meet with the service's pharmacists.

## FINANCIAL IMPLICATIONS

The Ministry provided $1.7 million to support the PAD service in 2020/21.

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**Approved:**

May 31, 2021 - Mitch Moneo,ADM, Pharmaceutical, Laboratory and Blood Services Division

June 2, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# BC Centre for Excellence in HIV/AIDS

## TOPIC

The BC Centre for Excellence in HIV/AIDS (BC CfE) is the largest HIV/AIDS research and treatment facility in Canada and is operated by Providence Health Care, St. Paul's Hospital in Vancouver. The Ministry of Health funds the BC CfE to manage and administer the HIV/AIDS Drug Treatment Program with a key component to improve the health of British Columbians living with HIV/AIDS.

## CURRENT SITUATION

- The HIV/AIDS Drug Treatment Program distributes anti-HIV drugs at no cost to eligible British Columbians.
- BC CfE continues to apply the Treatment as Prevention model with a key component that a person who is on sustained and consistent effective HIV treatment can achieve a level of virus that is undetectable in standard blood tests, at which point they cannot spread the virus to others.
- BC CfE continues to follow Drug Treatment Program participants at 3-month intervals at which time routine blood sampling is performed. Information from all recipients is entered into a BC CfE database, providing data for clinical and virologic outcome studies of patients receiving antiretroviral therapy. These studies form the basis of ongoing revision to the BC CfE treatment guidelines.
- BC has exceeded the United Nations 90-90-90 targets of diagnosing, treating and having undetectable levels of HIV in 90% of patients[1]. In June 2021, The United Nations General Assembly will convene a high-level meeting on HIV/AIDS to commit to ending AIDS as an epidemic of concern by 2030 setting a 95-95-95 target for jurisdictions around the world.

## KEY FACTS

- Established in 1992, BC CfE operates in collaboration with the BC Centre for Disease Control, the Ministry, Providence Health Care, Faculty of Health Science-Simon Fraser University, Department of Medicine-University of BC, provincial health authorities, Oak Tree Clinic and First Nation Groups.
- BC CfE provides support and treatment services for persons living with HIV as well as advice and guidance regarding current HIV/AIDS treatment. BC CfE's mandate is to:
    - improve the health of British Columbians with HIV through the development, ongoing monitoring, and dissemination of comprehensive research and treatment programs for HIV/AIDS and related diseases;
    - develop rational and cost-effective research and therapeutic protocols and programs for the treatment of HIV and related diseases;
    - provide educational support programs to health care professionals; and
    - monitor the impact of HIV/AIDS on BC and conduct analyses of the effectiveness of programs for investigating and treating HIV and related diseases, including health and health system outcomes from the provincial implementation of HIV treatment as Prevention through the Seek and Treat for Optimal Prevention HIV/AIDS pilot and provincial program.
- BC CfE's therapeutic guidelines committee provides advice and guidance to physicians through ongoing updates of specific treatment guidelines based upon the best available evidence and the committee's interpretation of current best practices. The guidelines are reviewed quarterly, and outcomes are studied and are subsequently used to monitor the HIV disease burden at the population level.
- BC CfE works with the Canadian HIV Trials Network, University of BC and others to exchange treatment and research information, resource material and trial data, and to facilitate opportunities for formalized training of health care professionals.
- BC CfE's Director, Dr. Julio Montaner, is recognized globally in HIV-related research and care.
- HIV infected individuals who are residents of BC and who have been determined to be eligible for health care services and benefits receive comprehensive coverage through the Drug Treatment Program (all antiretroviral drug therapy at no cost) according to BC CfE's therapeutic guidelines. The Ministry, through the Pharmaceutical, Laboratory and Blood Services Division, provides funding for BC CfE to deliver the Drug

[1] BC CfE: World AIDS Day December 1, 2020, Minister of Health speaking points

Treatment Program.

- BC CfE also provides the Antiretroviral Outreach Program in Vancouver's downtown east side to increase access and uptake of antiretroviral drugs among marginalized populations.
- The rate of new HIV infections has decreased 18% from 2015 to 2018 from a rate of 5.0 new diagnoses of HIV per 100,000 people in BC to 4.1 per 100,000 people.[2] In 2019, only 205 HIV cases were recorded, a record low.[3]
- BC has experienced a marked decrease in HIV/AIDS morbidity and mortality since implementation of the Highly Active Antiretroviral Therapy (HAART) treatment regimen in 1996. HAART consists of treating patients with a combination of 3 or more antiretroviral medicines. There is a strong association between increases in those receiving HAART and fewer new HIV diagnoses due to decreases in the amount of virus circulating within the population.[4,5]
- Effective January 1, 2018, British Columbians at high-risk are able to receive medication for pre-exposure prophylaxis of HIV to reduce the risk of acquiring HIV infection, at no cost (see Factsheet: *Pre-exposure prophylaxis of HIV).*
- Effective January 1, 2018, the existing post-exposure prophylaxis program, which primarily targets occupational exposures, was expanded to include coverage for non-occupational exposures.
- As of December 2020, approximately 7,400 persons were receiving HAART from the drug treatment program through BC CfE.[1] These treatments have been free for all BC residents since 1996.
- Starting on May 4, 2020, the dispensing pharmacies for the BC CfE began entering antiretroviral (ARV) prescriptions in PharmaNet. The Ministry made this decision with the utmost consideration to patient privacy, and with consideration of views from health care providers and advocacy groups that inclusion of ARVs in PharmaNet would provide greater safety to patients than harm. The PharmaNet system has strict access controls, and Ministry expects all health care professionals that access the system to honour their profession obligation to patient confidentiality.
- In December 2020 a new BC-CfE walk-in clinic was opened at 625 Powell Street: The Hope to Health Research and Innovation Clinic. The clinic was established through the contribution of 2 generous donors, and operates with the support of the Ministry of Health, as well as Vancouver Coastal Health and Providence Health Care. It serves people with opioid addictions, mental health and other health issues, including HIV and hepatitis C.

## FINANCIAL IMPLICATIONS

- The Ministry currently has a multi-year contract which has recently been extended to March 2022 (October 2018-March 2022) with the BC CfE for a total of $355 million over the 4-year term to deliver the Drug Treatment Program. This contract is managed by the Pharmaceutical, Laboratory and Blood Services Division.
- Oversight and governance of the agreement with the BC CfE is done through the Joint Funding Management Committee.
- BC CfE also receives funding from institutions such as the Canadian Institutes of Health Research and the US National Institutes of Health.

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**Approved:**

June 3, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 7, 2021 - Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
June 7, 2021 - Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division

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[2] Reportable Diseases Data Dashboard. (n.d.-b). Retrieved January 23, 2020, from http://www.bccdc.ca/health-professionals/data-reports/reportable-diseases-data-dashboard

[3] BC CfE: World AIDS Day December 1, 2020, Minister of Health speaking points

[4] Montaner, Julio S. G., Viviane D. Lima, Rolando Barrios, Benita Yip, Evan Wood, Thomas Kerr, Kate Shannon, et al. "Association of Highly Active Antiretroviral Therapy Coverage, Population Viral Load, and Yearly New HIV Diagnoses in British Columbia, Canada: A Population-Based Study." *Lancet (London, England)* 376, no. 9740 (August 14, 2010): 532–39. doi:10.1016/S0140-6736(10)60936-1.

[5] Hogg, R. S., B. Nosyk, P. R. Harrigan, V. D. Lima, K. Chan, K. Heath, E. Wood, T. Kerr, and J. S. G. Montaner. "Rates of New Infections in British Columbia Continue to Decline at a Faster Rate than in Other Canadian Regions." *HIV Medicine* 14, no. 9 (October 2013): 581–82. doi:10.1111/hiv.12079.

# LEGISLATIVE SESSION - FACT SHEET

## Biosimilars

### TOPIC

- A biosimilar is a drug demonstrated to be highly similar to a biologic drug that is already authorized for sale in Canada (known as the reference, innovator or originator biologic).
- Because the production of biologics is complicated and the molecules themselves are complex, an originator and biosimilar are very similar, but not identical.
- To be approved in Canada, Health Canada evaluates whether the information provided by the manufacturer shows that the biosimilar and the reference biologic are highly similar and there are no clinically meaningful differences in efficacy and safety between the biosimilar and the reference biologic.
- Some clinicians and patients are reluctant to support the use of biosimilars due to concerns that the biosimilar will not work as well as the innovator biologic, despite there being good evidence and experience from European countries that biosimilars are clinically equivalent.
- Listing biosimilars as PharmaCare benefits provides significant savings to the Ministry, depending on their utilization and on the price negotiations of the pan-Canadian Pharmaceutical Alliance (pCPA).
- Manufacturers of the originator biologics have a significant financial incentive to aggressively maintain their market share.

### CURRENT SITUATION

- In 2019 PharmaCare launched a Biosimilars Initiative to switch patients using originator biologics to their biosimilar versions. Patients had to visit a prescriber and get a new prescription switching to a biosimilar to maintain their PharmaCare coverage.
- In 2020 and 2021, the Biosimilars Initiative was expanded to include new biologics.

| Originator Product | Biosimilar | PharmaCare Covered Indications |
|---|---|---|
| Infliximab (Remicade) | Infliximab (Inflectra) | Rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), plaque psoriasis (PS), adult and pediatric Crohn's disease (CD), adult and pediatric ulcerative colitis (UC) |
| | Infliximab (Renflexis) | RA, AS, adult and pediatric CD, adult and pediatric UC, PsA, PS |
| Filgrastim (Neupogen) | Filgrastim (Grastofil) | Prevention and/or treatment of neutropenia |
| Etanercept (Enbrel) | Etanercept (Brenzys) | AS, RA, PsA (2021), PS (2021) |
| | Etanercept (Erelzi) | AS, RA, PsA, PS (2021) |
| Insulin glargine (Lantus) | Insulin glargine (Basaglar) | Type 1 and Type 2 diabetes |
| Rituximab (Rituxan) | Rituximab (Riximyo)<br>Rituximab (Ruxience)<br>Rituximab (Truxima) | RA<br>Relapsing-remitting multiple sclerosis (RRMS) Granulomatosis with polyangiitis (GPA)<br>Microscopic polyangiitis (MPA)<br>(Ruxience and Truxima are covered for GPA and MPA; Riximyo is not) |
| Adalimumab (Humira) | Adalimumab (Amgevita)<br>Adalimumab (Hadlima)<br>Adalimumab (Hulio)<br>Adalimumab (Hyrimoz)<br>Adalimumab (Idacio) | RA, AS, PsA, PsO (adults), HS (adults), polyarticular juvenile idiopathic arthritis (pJIA), CD, UC |

- **Phase I (May 27, 2019 to November 25, 2019) and Phase II (September 5, 2019 to March 5, 2020) (completed):** Patients using the originator biologic etanercept (Enbrel) for the treatment of AS,RA and PsA, patients usine Remicade for RA, AS, PsA, or PS (Phase I) and CD or UC (Phase II), and Lantus for treatment of Type 1 or Type 2 diabetes had to switch to their corresponding biosimilars.
- Based on PharmaNet claims date, one year after start of Phase I, 92% of PharmaCare etanercept patients, 81% of infliximab non-GI patients, and 86% of insulin glargine patients were on biosimilar versions of their respective drugs.
- One year after start of Phase II, 89% of infliximab PharmaCare GI patients were on biosimilars.
- **Rituximab phase (August 20, 2020 to February 18, 2021) (completed):** In this phase, all new and existing patients treated with Rituxan had to transition to one of three rituximab biosimilars (Truxima, Ruxience and

Riximyo). As of April 2021, 47% of patients transitioned to biosimilar versions of rituximab. Although this appears to be a low percentage, rituximab is given at at lest six-month intervals, therefore, it is expected that percentage will increase in the coming months as patients become due for next dose.

- **Adalimumab and etanercept for plaque psoriasis phase (April 7, 2021 to October 6, 2021):** In this phase, all new and existing patients treated with Humira have to transition to one of five adalimumab biosimilars (Amgevita, Hadlima, Hulio, Hyrimoz or Idacio); and patients receiving Enbrel for PsO have to switch to one of two etanercept biosimilars (Brenzys or Erelzi).
- **Other biosimilar work:**
- A third infliximab biosimilar (Avsola) was added to the formulary on February 18, 2021, and a fourth infliximab biosimilar (Remsima) is currently being negotiated by the pCPA (led by BC). Remsima is the first subcutaneous infliximab product and it is currently only indicated for rheumatoid arthritis.
- BC led pCPA negotiations for an insulin lispro biosimilar (Admelog) and implementation of coverage is in the planning stage.
- pCPA negotiations have been completed for three enoxaparin biosimilars (Redesca, Noromby and Inclunox) and implementation of coverage is also in the planning phase
- A fourth rituximab biosimilar (Riabni) is currently starting negotiations by the pCPA.
- The first insulin aspart biosimilar (Trurapi) has begun negotiations at the pCPA (originator is Novorapid)
- BC is leading the development of a pCPA biosimilars framework

## KEY FACTS

- As part of the Biosimilars Initiative, the Ministry is monitoring not only number of patients that switch from the originator to a biosimilar, but also physician visits, emergency room visits, hospitalizations, use of other medications such as corticosteroids in patients with Crohn's disease and ulcerative colitis, and patients switching to a different biologic.
- As of June 1, 2019, the Canadian Agency for Drugs and Technologies in Health (CADTH) no longer reviews biosimilars as following the existing Common Drug Review (CDR) process may delay access to new biosimilar treatments, and a better use of CADTH's limited resources would be to concentrate on other drug reviews.
- PharmaCare also no longer requires the Drug Benefit Council (DBC) to review biosimilars as Health Canada's review of biosimilars is thorough and without compromise to patient safety. Unless there is an exceptional reason for the CDR or the DBC to review a specific biosimilar, these reviews are now conducted internally.
- BC participates in the pCPA with other Canadian drug plans. BC and other jurisdictions negotiated prices through the pCPA for biosimilars that provide good value through lower transparent prices for all Canadians.
- Alberta, New Brunswick and Quebec have biosimilar policies similar to BC in place that require patients to switch to biosimilars from originator products.

## FINANCIAL IMPLICATIONS

- Biosimilars are significantly less expensive than their respective originator biologics. For example, the transparent price for Inflectra represents a reduction of 47% from the price of Remicade. This represents a significant savings, not only to the public drug plans, but to individuals and private drug plans as well.
- In 2019/20, PharmaCare spent $364.1 million on all biologic therapy[1].
- In 2019/20, PharmaCare saved $14.69 million through Biosimilars Initiative Phase I and II[2].
- CONFIDENTIAL: Government Financial Information
  Government Financial Information
- In the news release, it was reported that BC will save over $100M over 3 years.

**Approved:**
February 11, 2021– Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
February 9, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
June 14, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services

[1] PharmaNet, Health Sector Information, Analysis and Reporting, October 2, 2020
[2] PharmaNet, Health Sector Information, Analysis and Reporting, February 2, 2021

# LEGISLATIVE SESSION - FACT SHEET

# Blood Glucose Test Strips – Coverage Limits

## TOPIC

- BC PharmaCare limits the number of blood glucose test strips (BGTS) it covers for a patient each calendar year.
- This policy is based on research that shows more frequent blood glucose testing has a limited benefit for most people with diabetes who do not use insulin.

## CURRENT SITUATION

- Pharmaceutical, Laboratory and Blood Services Division (PLBSD) monitors the impact of this policy as data becomes available.
- PharmaCare has received few complaints since the policy was instituted in 2015.

## KEY FACTS

- PharmaCare provides coverage for BGTS to patients with diabetes who require testing and who have received a certificate of training from an accredited Diabetes Education Centre (DEC).
- Patients covered under Plan W (First Nations Health Benefits) may contact the First Nations Health Authority in lieu of a DEC to activate PharmaCare coverage of BGTS.
- On January 1, 2015, PharmaCare began applying annual quantity limits to the number of BGTS that are reimbursed per patient per calendar year. There was no limit on the number of strips covered by PharmaCare for eligible patients prior to 2015.
- The quantity limits are aligned with those recommended by Diabetes Canada and in Ontario.
- When a claim is submitted for BGTS, the PharmaNet system reviews all claims submitted in the previous 180 days for diabetes medications**,** whether or not the medications are covered by PharmaCare, and assigns the patient to one of four BGTS categories.
- The categories are determined by the type of diabetes-related medications a patient is taking, if any.
- There may be exceptional clinical circumstances in which patients need additional test strips above their annual quantity limit.
- Requests for coverage of additional strips, up to the maximums indicated below, can be made through the PharmaCare Special Authority process by a patient's doctor or healthcare professional at an accredited Diabetes Education Centre.
- In the rare case that a patient has a medical need to test even more frequently, or if they take insulin and need to test more frequently, their endocrinologist can submit a request to PharmaCare for additional strips. Requests are considered on a case-by-case basis.
- The four patient BGTS categories and the associated annual quantity limits for BGTS are as follows:

| Patient BGTS Category | Annual Quantity Limits | Annual Exception Limit |
|---|---|---|
| Managing diabetes with insulin | 3,000 | No additional allowance |
| Managing diabetes with anti-diabetes medications with a higher risk of causing hypoglycemia | 400 | 100 |
| Managing diabetes with anti-diabetes medications with a lower risk of causing hypoglycemia | 200 | 100 |
| Managing diabetes through diet/lifestyle | 200 | 100 |

- Reducing the frequency of self-monitoring of blood glucose (SMBG) can have positive effects on patients and on the overall health system. For example, reduced SMBG can result in:
    - Decreased lifestyle disruption for patients;
    - Greater focus on overall diabetes management, rather than monitoring; and
    - Significant savings for the overall health system.

# LEGISLATIVE SESSION - FACT SHEET

Policy Development

- In 2009, the Canadian Agency for Drugs and Technologies in Health (CADTH) reported that SMBG does not improve glycemic control in diabetes patients not treated with insulin; CADTH thus does not recommend routine use of SMBG for most of these patients.[1]
- In 2010, PLBSD developed and launched a multi-faceted education campaign involving a public forum and live presentations to promote evidence-informed use of BGTS in BC.
- In 2011, Diabetes Canada (then the Canadian Diabetes Association) published a commentary for healthcare providers that recognized that some limits on the number of BGTS reimbursed for patients taking oral anti-diabetes medications may be reasonable.[2]
- In February 2014, PLBSD engaged with stakeholders (e.g., Diabetes Canada, healthcare professionals, BC Pharmacy Association, etc.) and discussed options to address the utilization of BGTS, including limiting the quantity of BGTS being reimbursed. Common aspects of the options included the identification of patient categories eligible for BGTS coverage and their respective maximum annual BGTS limits, the need for exceptions to the annual allowance, and a list of exceptions.
- Following the review of the PharmaCare BGTS coverage policy and the input from key stakeholders during the February 2014 engagement session, the Ministry of Health announced a policy with BGTS quantity limits on November 27, 2014; the policy was launched January 1, 2015.

## FINANCIAL IMPLICATIONS

- PharmaCare spending on BGTS in 2020 was $16.16 million[3]. This was a decrease in PharmaCare expenditure for BGTS by $8.14 million[4] as compared to that in 2014.

Government Financial Information

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**Approved:**

January 21, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
March 23, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division
February 25, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

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[1] Optimal Therapy Recommendations for the Prescribing and Use of Blood Glucose Test Strips. Available online at: http://www.cadth.ca/media/pdf/compus_BGTS_OT_Rec_e.pdf

[2] http://www.diabetes.ca/getmedia/ab93def3-6da4-4b1e-92af-8e026635de11/self-monitoring-of-blood-glucose-briefing-english.pdf.aspx (*Canadian Journal of Diabetes*; Sept 2011)

[3] PharmaNet data, Health Sector Information, Analysis and Reporting Division, Ministry of Health, September 3rd, 2020.

[4] PharmaNet data, Health Sector Information, Analysis and Reporting Division, Ministry of Health, September 3rd, 2020.

# LEGISLATIVE SESSION - FACT SHEET

# Blood Services

## TOPIC

BC's participation in Canada's national blood system.

## CURRENT SITUATION

**Impact of COVID-19**

- Blood supply – Impacts to the supply and demand of blood and blood products that occurred during the early stages of the COVID-19 pandemic have been resolved. The National Emergency Blood Management Committee continues to monitor the situation.
- Immune globulin (Ig) – A shortage of Ig (a life-saving treatment derived from blood plasma) has been averted, however specific intravenous Ig products may be at risk within six months[1] due to disruptions in the global Ig supply chain caused by the COVID-19 pandemic. Global manufacturing has slowed due to staff absenteeism and plasma collections have decreased in the US. The National Advisory Committee on Blood and Blood Products has developed an interim Ig Shortages Plan and the Ministry of Health is monitoring and is identifying alternative efficacious therapeutics instead of Ig for appropriate conditions.

**Plasma Protein Products**

- Canadian Blood Services (CBS) procures and distributes plasma protein products (PPPs) through the blood system. CBS has discretion to add new brands of products; however, new categories of PPPs must be approved by Provincial/Territorial (PT) Deputy Ministers of Health. The process for the review of new categories of PPPs is currently under review by provinces, territories and CBS to ensure that blood products are reviewed with the same rigor and objectivity as pharmaceutical drugs. An Interim process, based on the Common Drug Review process, was put in place on November 26, 2019.
- Once a new category of PPP receives approval, CBS procures the product through a Request for Proposal process and distributes directly to hospitals at no cost to either hospital or patient. The Ministry pays CBS directly for all products ordered by BC hospitals.

**Plasma Self-Sufficiency**

Demand for Ig has been growing steadily at a rate of seven to eight percent annually[2]. The long-term impacts of COVID-19 are expected to further strain the supply. Only 13.7 percent[3] of the plasma currently required to manufacture Ig for Canadian use is collected from Canadian donors (via CBS). To increase Canada's plasma self-sufficiency, CBS has opened two new plasma collection sites with a third to be opened in Kelowna in June 2021[4]. An additional 2 sites are scheduled to open in Ontario in 2021-22.

**Organs and Tissues**

In 2008, CBS was given a mandate for organ and tissue donation and transplantation. For detailed information, please see the *Organ and Tissue Donation and Transplantation* Fact Sheet.

## KEY FACTS

- CBS is a national not-for-profit organization established in 1998 by a Federal/Provincial/Territorial Memorandum of Understanding to supply blood, blood products and their alternatives to provincial and territorial health systems (except Québec, which has its own blood system).
- CBS was established following the Royal Commission of Inquiry on the Blood System in Canada (the Krever Inquiry) and replaced the Canadian Red Cross Society as the blood system operator.
- PT Ministers of Health are the Corporate Members of CBS and are responsible for the mission, mandate and funding of CBS; approving a rolling three-year corporate plan and annual budget; electing directors to the CBS board; and, overall expenditure of public funds by CBS.

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[1] Source: 2020 12 15 CBS Customer Letter #2020-50
[2] Source: 2021-2024 Corporate Plan (received July 31, 2020) – p. 41
[3] Source: 2021-2024 Corporate Plan (received July 31, 2020) – p. 52
[4] Source: 2021-2024 Corporate Plan (received July 31, 2020) – p. 55

- CBS operates at arm's-length from governments and is responsible for providing a safe, secure and affordable supply of blood, blood products and their alternatives. PT Ministers of Health do not direct operational decisions of the CBS Board of Directors or its staff.
- In addition to the national blood system, the BC Provincial Blood Coordinating Office, a program within the Provincial Health Services Authority, is responsible for coordinating blood and blood product utilization within the province and managing specialized provincial resources. The Provincial Blood Coordinating Office is designed to work within the framework of the national system. Responsibilities include:
    - Operating the Central Transfusion Registry of all patient blood and blood product transfusions in BC and the Yukon. The Central Transfusion Registry supports transfusion medicine clinical practice, utilization management programs for red blood cells and PPPs, quality and safety initiatives, and surveillance tracking.
    - Managing the red blood cell redistribution program, which helps to minimize waste from product outdating. Smaller hospitals send blood that is 10 to 14 days from expiry to a designated larger hospital where it is more likely to be used.
    - Managing the Immune Globulin Utilization Management program which ensures appropriate and cost-effective use of these products.
    - Managing the Transparent Blood Inventory System, which provides health authorities, transfusion medical directors and CBS with visibility into the quantity and location of blood components in hospital inventories throughout the province. In the event of product shortfalls, inventory can be moved to ensure appropriate patient care.
    - Maintaining the BC Blood Contingency Plan, which is designed to ensure a consistent, coordinated approach across the province in the event of a blood shortage.

## FINANCIAL IMPLICATIONS

- CBS's budget is negotiated with PT Ministries of Health and approved annually in March by PT Ministers of Health (except Québec).
- 2019/20 CBS approved budget was $1.19 billion[5]; actual CBS expenditures were $1.18 billion[6].
- As part of BC's provincial financial commitment, the Ministry of Health provided $196.45 million in 2019/20 and $196.82 million in 2020/21 to CBS (unaudited).
- 2021/22 CBS national budget will be submitted to PT Ministers of Health for approval in 2021.

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**Approved:**
June 3, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 10, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[5] Source: 2019-20 Budget Agreement Letter – p1.
[6] Source: CBS 2019/20 Non-Consolidated Financial Statements, Schedule 3.

# LEGISLATIVE SESSION - FACT SHEET

## Canadian Agency for Drugs and Technology in Health

### TOPIC

- The Canadian Agency for Drugs and Technologies in Health (CADTH) is an independent, not-for-profit national body funded by Canada's federal, provincial, and territorial (F/P/T) governments.
- CADTH provides health care decision-makers with credible, independent advice and evidence-based information about the effectiveness, efficacy and safety of drugs and other health technologies.
- CADTH's core programs are: Common Drug Review (CDR); Health Technology Assessment; Optimal Use Projects; pan-Canadian Oncology Drug Review (pCODR); Rapid Response Service; Environment Scanning and Horizon Scanning.

### CURRENT SITUATION

- As of January 19, 2021, CADTH's CDR has issued recommendations for 543 drug submissions or resubmissions since the program began in September 2003.[1] An additional 62 reviews have been withdrawn, cancelled, or suspended.[2]
- As of January 19, 2021, the CDR has 40 active submissions and 12 submissions pending or received. [3]
- CADTH is funded through F/P/T contributions and, as of September 2014, by manufacturers application fees for all CDR reviews. As of January 19, 2021, application fees vary from $7,150 for a request for reconsideration of an embargoed or initial recommendation to $128,500 for a submission or resubmission reviewed through the process for drugs with expanded health system implications.[4]

### KEY FACTS

- BC is represented on the Board of Directors by the ADM of Pharmaceutical, Laboratory and Blood Services Division, Ministry of Health.
- BC is also represented on the Pharmaceutical Advisory Committee, an F/P/T committee responsible to provide strategic advice to CADTH.
- There are BC representatives on the Pharmaceutical Advisory Committee's working groups, which support and advise the CDR (Formulary Working Group), and pCODR (Provincial Advisory Group).
- The CDR is a pan-Canadian process for conducting objective, rigorous reviews of the clinical and cost effectiveness evidence for drugs and providing formulary listing recommendations to participating publicly-funded drug plans.
- Publicly funded plans participating in the CDR include the provincial and territorial drug plans (except Quebec, which has its own review process), and 6 federal drug insurance plans.
- The CDR recommendations are provided by the Canadian Drug Expert Committee, a pan-Canadian committee made up of leading experts in drug therapy, drug evaluation, pharmacoeconomics, and drug utilization (mostly practising physicians, pharmacists, and health economists), as well as representatives from the public.[5]
- The CDR also has a process for collecting Patient Group input that was developed in consultation with patient groups, the participating drug plans, and other international drug review agencies.[6]
- The CDR recommendations are an important and valued addition to the information that participating drug benefit plans, such as PharmaCare, consider when making drug listing decisions.
- CDR recommendations are forwarded to PharmaCare's Drug Benefit Council for consideration and recommendation for PharmaCare listing decisions in BC.

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[1] CDR Drug Database. Accessed August 31, 2020, from https://www.cadth.ca/about-cadth/what-we-do/products-services/cdr/reports
[2] Ibid.
[3] Ibid.
[4] Guidelines for Manufacturers on Application Fees for CADTH Pharmaceutical Reviews, accessed August 31, 2020 https://www.cadth.ca/sites/default/files/cdr/CADTH_Application_Fees.pdf
[5] See https://www.cadth.ca/about-cadth/what-we-do/products-services/cdr
[6] See https://www.cadth.ca/about-cadth/what-we-do/products-services/cdr/patient-input

- CADTH's Health Technology Assessment work is utilized by the Ministry and the health authorities to inform coverage or policy developments. Recent assessments include a benefit analysis of Flash Glucose Monitoring Systems for People with Type 1 or Type 2 Diabetes.
- Optimal Use Projects are typically large projects involving systematic reviews of clinical evidence, cost effectiveness analyses, and development of recommendations, guidance documents, and tools. Recent Optimal Use Projects includes a review of Internet-Based Cognitive Behavioural Therapy for Post-Traumatic Stress Disorder.

## FINANCIAL IMPLICATIONS

- Each year, the Ministry contributes approximately $616,000 to support the CDR program, approximately $468,000 to support the Health Technology Assessment program, $329,000 to support pCODR and approximately $54,000 to support the Canadian Standards Association Health Care Program.[7]
- Health Canada and other provinces and territories also fund CADTH. Optimal Use projects are fully funded by Health Canada.

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**Approved:**
January 27, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
January 28, 2021 – C. Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 10, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[7] Decision Support, Finance and Corporate Services, Ministry of Health

# LEGISLATIVE SESSION - FACT SHEET

# CETA, CUSMA (renegotiated NAFTA) and CPTPP Intellectual Property Rights

## TOPIC

Canada's Free Trade Agreements include intellectual property commitments that may increase the cost of drugs. This note provides an update on the status of recent trade negotiations that may impact these costs.

## CURRENT SITUATION

- On September 21, 2017, Canada and the European Union (EU) brought the Comprehensive Economic and Trade Agreement (CETA) into effect through provisional application. CETA is a mixed agreement, which requires Member State approval. Provisional application allows for up to 95% of the Agreement to be in effect while these approvals are completed after which the remaining 5-10% will be implemented. Under CETA, Canada agreed to make regulatory changes to allow drug patents to be extended for up to two additional years.
- The Comprehensive and Progressive Agreement for Trans-Pacific Partnership (CPTPP) is a trade agreement between Australia, Brunei Darussalam, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore and Vietnam. The CPTPP was formed by the 11 remaining members of the original Trans-Pacific Partnership (TPP) as a result of the US withdrawal from the TPP.
- The CPTPP contains important differences from the original TPP, including the suspension of several IP provisions (that had been of interest to the US under the TPP).
- The CPTPP did not require Canada to make any regulatory changes that will impact the cost of drugs.
- The CPTPP came into effect for the first six countries that ratified the Agreement – Canada, Australia, Japan, Mexico, New Zealand, and Singapore – on December 30, 2018. The CPTPP entered into effect for Vietnam on January 14, 2019. The remaining four countries have not yet completed their domestic ratification of the CPTPP.
- On November 30, 2018, Canada, the US and Mexico signed the renegotiated NAFTA – called the Canada-United States-Mexico Agreement (CUSMA) by Canada and the United States-Mexico-Canada Agreement (USMCA) by the US. Amendments to the CUSMA were subsequently signed on December 10, 2019; these amendments included changes to the IP provisions related to pharmaceutical drugs, reducing the previously anticipated financial impact of the CUSMA. Most notably, Parties agreed to remove the obligation on data protection for biologics, meaning that Canada will no longer need to amend its domestic regime to provide 10 years of data protection in this area. This change, and others, means that Canada will no longer be required to make changes to its domestic patent or pharmaceutical IP regimes in order to implement the amended provisions.
- The CUSMA entered into effect on July 1, 2020, replacing the NAFTA.

## KEY FACTS

- Patent legislation for pharmaceuticals was initially implemented in the 1980's and extended significant monopoly protections to manufacturers of patented drugs. In 1994, Trade Related Aspects of Intellectual Property Rights (TRIPS) concluded to provide common standardization and enforcement of IPR laws. TRIPS provisions provided exclusive rights for patent holders and extended patent rights of 20 years.
- Innovative Medicines Canada advocated for support from provinces/territories to maintain their intellectual property rights. The CETA changes allow their member companies to defer competition on patented drugs. Innovative Medicines Canada also asserted that the impact of these changes would not occur until 8 years following ratification (2026) as the changes would only apply to newly-approved drugs. The federal government has taken a similar position and maintains the cost impacts resulting from CETA will not likely be realized until 2026, if at all.
- During CETA negotiations, the Canadian Generic Pharmaceutical Association (CGPA) raised the negative economic impact on provincial drug programs, private plan sponsors and individuals. A CGPA-commissioned study estimated the changes could cost Canadians up to $2.8 billion per year due to the delayed availability

of generic drugs.1 While the foregoing cost projection may be overstated, the changes made under the CETA will delay the launch of new generics (by up to 2 years) and could result in a significant cost to payers.

- The CGPA publicly stated support for the CETA's "Right of Appeal" provisions which aimed to address excessive and duplicative litigation by ending the practice of dual litigation. The CGPA has long advocated for such reforms to Canada's pharmaceutical patent linkage system.
- On April 26, 2018 the Office of the Parliamentary Budget Officer released a report "Patent Restoration and the Cost of Pharmaceuticals" that estimated annual costs for public drug plans nationally to be $270 million and $28 million for BC.
- The conduct of trade negotiations such as the CETA as well as the legislation regarding patents is within the exclusive jurisdiction of the Federal Government.
- The Ministry of Jobs, Economic Recovery and Innovation (JERI) is engaged with the federal government to represent BC's interests with respect to all international trade negotiations. The Ministry of Health is providing advice to JERI including on pharmaceutical patent issues.
- BC reserves the right to review any agreement in detail before commenting on whether the Province will be requesting compensation from the federal government if drug costs are affected. Compensation has been requested from the federal government for drug costs related to CETA.

## FINANCIAL IMPLICATIONS

- Future launches of new generic drugs are expected to generate a significant amount per year in aggregate savings for BC PharmaCare. Based on the information available there will be a delayed entry of new generics due to patent extensions as a result of CETA.
- The federal government made a commitment in the mandate letter of the Minister of International Trade to work with the provincial public drug plans on compensation related for incremental costs arising from the CETA. Provinces and territories had previously raised the issue of compensation as a result of outcomes in the CUSMA IP Chapter with the federal government; this is no longer required as a result of amendments made to the CUSMA IP Chapter.

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**Approved:**
October 2, 2019 – C. Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 6, 2020 - Brenda Rafter obo Dave Boychuk, CFO/Philip Twyford, ADM Finance and Corporate Services Division
June 1, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

[1] The Globe and Mail. *Why Canada Should Reject EU Demands on Pharma Patents.* Retrieved on February 2, 2015 from: http://www.theglobeandmail.com/report-on-business/economy/economy-lab/why-canada-should-reject-eu-demands-on-pharma-patents/article4651325/

# LEGISLATIVE SESSION - FACT SHEET

## Clinical Evidence Reviews

### TOPIC

- The Ministry of Health receives drug submissions from manufacturers, the majority of which are first reviewed through the national Common Drug Review (CDR).
- On occasion, the Ministry may receive a drug submission directly from the manufacturer when it does not meet the CDR criteria, or the Ministry may initiate a review of a drug or a therapeutic review-based identification of a need for such a review (i.e. change in clinical practice, new evidence, etc.).
- In such instances, the Ministry needs resources to complete clinical evidence reviews.

### CURRENT SITUATION

As of January 19, 2021, the Ministry has a contract with the Therapeutics Initiative (TI). Contracts with ReVue Drug Evaluation Group Inc. and Medlior Health Outcomes Research Ltd. have recently expired.

### KEY FACTS

- The Ministry makes PharmaCare coverage decisions based on a range of considerations including existing PharmaCare policies, programs, therapeutic options, resources and the evidence-informed recommendations of an independent advisory body called the Drug Benefit Council (DBC).
- Prior to the establishment of the national CDR in 2003, the TI provided most reviews of drug submissions to the DBC.
- Today, the DBC is responsible for making drug listing recommendations to the Ministry and the Ministry is ultimately the decision-maker. Since 2003, the majority of newly patented drugs are reviewed by the CDR.
- In 2014, following the expiry of the earlier contracts, the Ministry posted a request for proposal process on BC Bid. One of the University of BC (UBC) drug researchers, who is a member of the TI, won a new 3-year contract to deliver the next round of Clinical Evidence Review services to inform the Ministry's drug review process. Two other contractors, ReVue Drug Evaluation Group Inc. and Medlior Health Outcomes Research Ltd. were also successful.
- The TI contract for clinical evidence reviews was terminated in September 2017 as there is a new contract in place (see TI Fact Sheet for more information).
- In 2018, ReVue Drug Evaluation Group Inc. and Medlior Health Outcomes Research Ltd. contracts were extended two years. In 2020, the contracts were renewed for an additional six months to prevent gap in service until new contracts can be issued; a request for proposals to secure the next round of Clinical Evidence Review services began in Spring 2020.
- The procurement phase was paused during the October interregnum and will resume as the new government approves expenditures for new contracts.
- Revue Drug Evaluation Group Inc. signed a subsequent Modification Agreement in September 2020 in order to complete a Clinical Evidence Review on low molecular weight heparin in cancer-associated thrombosis.

### FINANCIAL IMPLICATIONS

- In 2014, a Request for Proposals for Clinical Evidence Review services was issued through the BC Bid process. Service contracts were awarded to:
    - ReVue Drug Evaluation Group Inc. (Oakville, Ontario);
    - Medlior Health Outcomes Research Ltd. (Calgary, Alberta); and
    - UBC drug researcher from the UBC-TI (Vancouver, BC).
- The now terminated contract with the TI was valued at a maximum funding of $170,000 per year.
- In 2018 Modification Agreements for two Clinical Evidence Review contracts were signed extending the contracts from April 2018 to April 2020:
    - Total value of the ReVue's five-year contract was $850,000.
    - Total value of the Medlior's five-year contract was $300,000.
- In 2020, an additional Modification Agreement for the two Clinical Evidence Review contracts was signed extending them from April to September 2020. No additional funding was added to the 6 month extension.

# LEGISLATIVE SESSION - FACT SHEET

- In September 2020, a subsequent Modification Agreement was signed with ReVue Drug Evaluation Group Inc. allowing them enough time to finish a Clinical Evidence Review on low molecular weight heparin in cancer-associated thrombosis. No additional funding was added to the extension. The modification lasted until December 31, 2020.

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**Approved:**
January 27, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 11, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Continuous and Flash Glucose Monitors

## TOPIC

- Diabetes is a chronic metabolic disorder that interferes with the body's ability to produce or effectively use insulin. There are two main types of diabetes, Type 1 diabetes and Type 2 diabetes.
- There is no cure for diabetes, but there are a number of ways to manage the disease. People with Type 1 diabetes, and some people with Type 2 diabetes, require a form of insulin delivery.
- People with diabetes must monitor their glucose (blood sugar) levels to confirm and treat low blood sugar, or hypoglycemia, to adjust their dosage of insulin, and to provide information to their health care providers about their diabetes management.
- The most common method of monitoring blood glucose is self-monitoring blood glucose (SMBG) but continuous glucose monitoring (CGM) and flash glucose monitoring (FGM) are gaining in popularity.

## CURRENT SITUATION

- CGM and FGM devices are very expensive and may not be affordable for many patients. According to a Health Technology Assessment (HTA) report on these technologies that was commissioned by the BC Ministry of Health, the estimated annual per patient cost of using an FGM is $3,265, and a CGM is $4,438.[1]
- The BC Health Technology Advisory Committee (HTAC) has 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'sworking group reviewed the findings from the 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 CGMs and FGM devices and Dexcom CGM is a successful candidate.

## KEY FACTS

- Using SMBG, patients monitor their blood glucose by pricking their fingers with a lance and delivering a drop of blood onto an enzyme-coated test strip. A meter reads the blood glucose level and displays the result for the patient to read. This process must be repeated several times a day and provides accurate, but intermittent, blood glucose readings. Patients may find that repeated needle pricks are painful and inconvenient.
- CGM devices consist of three parts: a needle-like sensor that is inserted and attached to the surface of the skin; a transmitter that relays information from the sensor; and a portable monitor (or a compatible smartphone) which receives the signal and displays the glucose measurement results.
- The advantages of CGM devices are alarm features that alert patients to deviations from recommended blood glucose levels, enabling them to take corrective action sooner and allow patients to view their glucose trends and time spent in and outside of the target glycemic range, known as "time in range."
- Similar to CGM devices, FGM devices consist of a sensor with a fine, needle-like filament that is inserted into the skin and the sensor is continuously worn on the surface of the skin.
- FGM devices differ from CGM devices in that they do not continuously send blood glucose readings to the monitoring device but, rather, provides a result via scanning a reader device (or compatible smartphone) on the sensor. Similar to CGM devices, FGM devices also allow patients to view their glucose trends and time spent in and outside of the target glycemic range, known as "time in range." Newer versions of the FGM devices, such as the Freestyle Libre 2, have optional alarms to alert patients of deviations from their recommended blood glucose levels.

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[1] Health Technology Assessment Unit, University of Calgary, *Glucose monitoring technologies for the management of insulin-dependent diabetes* June 2019 (223).

- Effective September 16, 2019, Ontario announced funding for FreeStyle Libre FGM 14-day sensors and readers through the Ontario Drug Benefit (ODB) program for patients managing diabetes with insulin. They join Quebec as the only two provinces to provide public funding for these devices.
- The HTAC's review, assessing the efficacy and cost-effectiveness of CGM and FGM technologies, provided the following recommendations:
    1. As the current evidence suggests glucose monitoring technologies, including CGM, FGM, and hybrid closed loop insulin delivery systems, provide no additional clinical benefits compared to finger-prick blood glucose tests but provide non-clinical benefits such as added comfort, convenience, and flexibility in diabetes management, HTAC recommends funding for FGMs, the most cost-effective option assessed.
    2. HTAC recommends funding for FGMs be provided based on functional, not clinical, need. The Ministry should consult relevant stakeholders to define eligible populations that may or may not include children, adults with some level of either cognitive and/or physical disability, and adults whose occupation makes finger-pricking challenging.
    3. HTAC recommends reviewing glucose monitoring technologies again when compelling new evidence of their clinical benefits becomes available.
- CADTH's publications from September 2020 consisted of three parts:
    1. A synthesis of Canadian HTA reports from CADTH/Health Quality Ontario (HQO) and the Institut national d'excellence en santé et services sociaux (INESSS); CADTH concluded that, based on the 2 HTA reports, there is limited evidence supporting the effect of FGM devices with regard to the quantity and quality of the evidence.
    2. A synthesis of the 2 provincial recommendations (HQO and INESSS); both provinces recommended funding the FGM devices with clinical criteria.
    3. Implementation advice from an expert panel, using the above report and their own expertise. The implementation advice identified specific populations expected to benefit the most from using a FGM device.
- On June 11, 2021, BC announced coverage for Dexcom G6 CGM as a Limited Coverage. Patients with diabetes that meet the criteria will now be eligible for PharmaCare coverage subject to their plan rules and deductables.

## FINANCIAL IMPLICATIONS

- The Ministry completed a competitive value process for CGMs and FGM. Dexcom G6 CGM was a successful candidate.
- It would have cost approximately $100 million over three years to implement coverage for the Dexcom G6 CGM. The Province successfully negotiated a discount.
- CONFIDENTIAL: Government Financial Information

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**Approved:**
January 26, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis, and Reporting
February 8, 2021 - Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
June 14, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory & Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Contract with Valley Medical Laboratories

### TOPIC

- Due to COVID-19 restrictions, Valley Medical Laboratories (VML) experienced a significant reduction in patient visits and thus Medical Service Plan fee-for-service revenue. To assist VML and ensure outpatient services continue to be delivered in the Okanagan Valley Region, the Ministry of Health (the Ministry) and VML signed a 1-year General Service Agreement (the Agreement), effective April 1, 2020, for the provision of community-based laboratory services in the Interior Region of the province.
- VML is interested in negotiating a new long-term Laboratory Services Agreement with the Ministry exploring alternative funding models to move away from fee-for-service[1] and has signed a letter confirming their intention to begin negotiations with government in June 2021[2].

### CURRENT SITUATION

- VML is a private laboratory provider within the province and the largest commercial supplier of laboratory test services in the Okanagan region, operating 14 patient service centres (PSC) and providing laboratory services for 1,874 patient visits per day[3]
- VML is a General Partnership registered in British Columbia, owned/operated by Dr. L.H. Argatoff, Inc. and Dr. Douglas Hardy, Inc. and Lesack, David W. et al.
- VML services include (a) Pre-analytical services - collection and transportation of specimens, including mobile collection for 40 long-term care and assisted living facilities in the Interior, and distribution of testing kits; (b) Analytical (laboratory testing) services; (c) Post-analytical services - including results distribution, reporting to public health entities, critical results management, storage of patient information aligned with applicable privacy laws, call centre services for patients and providers, and medical consultations with clinicians (d) Other supporting services – including laboratory testing information for patients, consultation services with practitioners and maintenance of the VML website; and (e) Provision of current and functional information management services and information technology services.
- The Interior Health Authority relies on the outpatient laboratory services provided by VML and would not have been able to accommodate the additional volume should VML wind down operations during the pandemic. There are currently no other service providers available in the area, with the ability to accommodate the required capacity in a short timeframe, to support outpatient services.
- The Agreement expired March 31, 2021, and VML has reverted back to the Medical Service Plan fee-for-service funding model (without additional "top-up" funding) and to the Facility Approvals process under the *Laboratory Service Act* (LSA). Final reconciliation of the Agreement will begin in July 2021.
- VML is interested in negotiating a new long-term Laboratory Services Agreement with the Ministry[4] and has signed a letter confirming their intention to begin negotiations in June 2021[5].

### KEY FACTS

- The LSA, brought into force in October 2015, created the authority for the Minister of Health to enter into agreements with private laboratory service providers.
- As a result of COVID-19 pandemic restrictions, VML had a significant reduction in patient visits resulting in reduced billings of $851,000 in March 2020, due to patient volume reduction/revenue reduction of 40% ,[6] which is material to company operations.

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[1] Ministry of Health Decision Briefing Note (Division Ref# 1174992).

[2] Ministry of Health, Valley Medical Laboratories and Provinical Health Services Authority Letter of Intent (April 1, 2021)

[3] Valley Medical Laboratories Monthly Performance Update (March 2021)

[4] Ministry of Health Decision Briefing Note (Division Ref# 1174992).

[5] Ministry of Health, Valley Medical Laboratories and Provinical Health Services Authority Letter of Intent (April 1, 2021)

[6] Ministry of Health Contract Issue Note (Division Ref# PHLHS-2020-04).

- To enable the immediate restoration of services in the Okanagan Valley, sustain existing infrastructure, and manage the significant decrease in billings and patient volumes, the Ministry and VML signed a 1-year agreement (effective April 1, 2020, to March 31, 2021) to assist VML with immediate cashflow and sustainability issues due to COVID-19.
- A strong governance structure for the contract was established with the Ministry, VML, and Provincial Health Services Authority, with senior executives tasked to monitor and manage the utilization of the funding under the Agreement, as well as to ensure that all historical basic services (pre-COVID-19) continued at reasonable levels and that resources were redeployed within the existing budget for 2020/21.
- VML provided full transparency to the province on any applications to, and money received from, federal government COVID-19 programs for industry. These amounts will be applied to the reconciliation process described in the Agreement.
- Within the Agreement, other reporting requirements for VML included an action plan and monthly performance reports describing: (a) the reopening of six PSCs that were closed due to the COVID-19 pandemic; (b) a workforce plan to retain VML employees working in the open PSCs; (c) the status of VML's offers to rehire or reinstate employees terminated/laid off due to COVID-19; (d) a list of resources (employees, supplies, etc.) required by VML to maintain operations during the pandemic, and an estimate of the number of employees that could have been deployed to the Interior Health Region or Northern Health Region.

## FINANCIAL IMPLICATIONS

- Funding for the Laboratory Services Agreement with VML was within the MSP's Laboratory Fee-for-Service budget.
- Annual fee-for-service payments to VML were approximately $16.1 million in 2018/19 and $15.8 million in 2019/20.[7]
- The maximum amount payable under the Agreement with VML was $15.36 million (fixed fee and fee for service) less the value of all subsidies (e.g., money received from federal government COVID-19 programs for industry).[8]
- As per the Agreement, the maximum amount in fixed fee payments from April to September 2020/21 was $4.98 million ($830,000 per month). However, the actual fixed fee payment was $830,000 per month from April to July 2020, $128,000 per month for August and September, and no more payments after September 2020, as VML's patient throughput and test volumes had mostly recovered.

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**Approved:**
June 3, 2021 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
June 8, 2021 - Brenda Rafter, A/ED, obo Philip Twyford, Finance and Corporate Services Division

[7] Ministry of Health Contract Issue Note (Division Ref# PHLHS-2020-04). 2018/19 and 2019/20 fee for service reports on payees 10006 and 10007.
[8] Ministry of Health General Service Agreement (Ministry Contract No.: 2021-024), with Valley Medical Laboratories.

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Laboratory Testing

## TOPIC

- Provincial Health Services Authority (PHSA), through Provincial Laboratory Medicine Services (PLMS), is leading implementation of BC's laboratory response to COVID-19 with support from the Ministry of Health.
- Through 2020/21, the Laboratory and Blood Services Branch (LBSB) represented the Ministry on the Provincial Lab Standing Operations Meeting for COVID-19 Response, supporting work to increase testing capacity and access, resolving issues and risks, engaging across divisions to provide strategic advice, developing laboratory services agreements, recommending regulatory changes, implementing payment schedule changes, and developing policy and guidance.
- PLMS is developing a Year 2 Business Case for the ongoing response to COVID-19. The business case will build on the the legacy of the COVID-19 experience, including the investments and innovations that emerged in 2020/21 to support an integrated, province-wide response to the pandemic.

## CURRENT SITUATION

- As of June 2, 2021, the Ministry was still waiting to receive the Year 2 Business Case.
- LBSB is continuing to monitor and support the response to COVID-19, including monitoring the impact of initiatives launched in 2020/21 to maintain the provincial target of 20,000 publicly funded tests/day. These initiatives include:

**System Enhancements**

- Installation of new equipment to increase capacity and offset equipment failures and supply shortages.
- Creation of the Lower Mainland Accessioning Centre to facilitate movement of specimens to sites with greater capacity, and enhancing province-wide supply chain logistics.
- Implementation of bi-directional interfaces between sites to minimize duplication of effort, free up staff and improve data accuracy and efficiencies for specimen transportation.
- Validating and implementing other approved tests and methodologies.
- Addressing health human resource shortages through training and recruitment, changes to scopes of practice and realignment of job descriptions to ensure the supply of Medical Laboratory Assistants, Medical Laboratory Technicians, Data Clerks and other personnel.
- Validating/deploying federally procured point of care tests (POCT) in accordance with BC's POCT Strategy.

**Partnerships and Agreements**

- At the request of the Ministry and PHSA, and in response to the growing need for capacity, LifeLabs performed COVID-19 testing at their Surrey Reference Laboratory (late March 2020 until March 31, 2021).
- The Ministry executed a separate agreement with LifeLabs for additional on-demand testing capacity in the event of a surge or outbreak (up to 2,400 tests/day from mid-September to December 31, 2020).
- LifeLabs provided support including logistics and transportation services for the Lower Mainland Accessioning Centre, and is working with some health authorities to establish bidirectional interfaces to send orders and results between the health authorities clinical information systems and LifeLabs, to reduce turn-around times and enable real-time reporting of COVID-19 results.
- In May 2020, a General Service Agreement was signed with Valley Medical Laboratories (VML) to provide additional funding for necessary outpatient laboratory services in the Okanagan region throughout the pandemic (April 1, 2020, to March 31, 2021).

**Fee Schedule**

- In April 2020, the Schedule of Fees for the Laboratory Services Outpatient Payment Schedule was amended to include a provisional fee item, effective January 1, 2020, for COVID-19 testing at $26.73 per test: P90837 – novel coronavirus disease 2019 (COVID-19 or 2019-nCoV) test

**Regulatory Changes and Scope of Practice**

- Under a May 2020 Provincial Health Officer (PHO) Order, Licensed Practical Nurses can perform nasopharangeal (NP) swab collection without a client-specific order as part of a screening program designated by the Medical Health Officer for their geographic area.

- An Order in Council to include RNs and RPNs as referring practitioners under the Laboratory Services Regulation was approved on June 17, 2020. A Ministerial Order (July 7, 2020) established a referring practitioner schedule for RNs and RPNs for the COVID-19 fee item, allowing RNs and RPNs to order COVID-19 tests as a benefit under the *Laboratory Services Act*.
- In November 2020, three PHO orders were signed to expand human resource testing capacity for the virus by enabling some health professionals who are not authorized to do testing to conduct NP and mouth rinses (including physical therapists, speech language pathologists, occupational therapists, dental hygienists, dietitians, audiologists, and pharmacists who are employees of a regional health authority, PHSA or FNHA, speech language pathologists and midwives, and BC Emergency Health Services Community Paramedics).
- Under a May 2021 PHO order, Advanced Care Paramedic and Critical Care Paramedics employed in industrial sites and "industrial camps" are allowed to conduct NP swabs and mouth rinses.
- These changes remain in effect for the duration of the COVID-19 public health emergency in BC.

## KEY FACTS

- BC's testing strategy recommends anyone with cold, flu or COVID-19-like symptoms be tested for COVID-19.
- Asymptomatic PCR testing is available as private pay through an increasing number of private labs and collection sites accredited by the Diagnostic Accreditation Program (DAP).
- On March 4, 2021, BC expanded its COVID-19 strategy to include publicly funded asymptomatic POCT in 4 priority populations.
- There continues to be significant interest in POCT for COVID-19 screening at worksites. On March 16, 2021, the PHO published a letter confirming that any site, laboratory, or company that charges for screening must be accredited through the DAP. Screening done at no cost to the client may instead follow the quality assurance process from the BC Centre for Disease Control Public Health Laboratory.
- Sample collection that employs NP swabs is restricted to regulated health care professionals. Collection using less invasive techniques (e.g., nasal swabs) is not restricted and can be performed by any individual who has been trained in the administration of the test.
- Any positive COVID-19 test result must be reported to public health. As of June, 2021, discussions were underway to determine if non-regulated professionals can be required to report results, and whether there is benefit to reporting results of POCT given all positive POCT results must be confirmed through PCR testing.
- Serological testing for COVID-19 is not offered in BC except in very limited circumstances as per public health guidance, but is available as private pay through LifeLabs and, on a limited basis, through Valley Medical.
- As of June 2, 2021, BC's testing capacity was just over 22,300 tests per day. Demand for testing is decreasing as vaccination rates increase. Capacity utilization is averaging 20% across the province[1].

## FINANCIAL IMPLICATIONS

- The Ministry budget for outpatient laboratory services (Medical Services Plan vote appropriation) will be impacted by the implementation of a COVID-19 fee-for-service test. However, non-COVID-19 outpatient laboratory testing volumes and the associated expenditures have decreased for public and private laboratory providers since the start of the pandemic.
- The financial impact of enabling RNs and RPNs to order COVID-19 tests is unknown at this time.
- The 2020/21 PLMS Surge Business Case funding request of $52,312,624 included operational and capital costs and the negotiated COVID-19 agreement with LifeLabs (to a maximum of $12.84 million) for on-demand testing capacity from September 16, to December 31, 2020.
- The Ministry has not received the Year 2 COVID-19 Business Case outlining an investment strategy or projected expenditures for 2021/22.

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**Approved:**
June 7, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 10, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] PLMS COVID Dashboard 2021-06-02 v1

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Whole Genome Sequencing Strategy

## TOPIC

- As of June 1, 2021, all positive COVID-19 samples are being sent to BC Centre for Disease Control (BCCDC) Public Health Lab for whole genome sequencing (WGS) to identify viral mutations (variants) including Variants of Concern (VoC).
- Sequencing the genome of all positive COVID-19 samples will make it possible to monitor the evolution of the pandemic including the introduction through travel of new COVID-19 variants and the impacts of vaccine on the SARS-CoV-2 virus.

## CURRENT SITUATION

- Since the emergence of COVID-19 in BC, whole genome sequencing at the BCCDC Public Health Lab (PHL) has been used to better understand the SARS-CoV-2 virus present in the BC population.
- In addition, throughout the first year of the pandemic (Year 1), BC health authorities were using a Lab Developed Test (LDT) to test all positive COVID-19 samples to confirm the presence of known variants. This was intended to continue until the prevalence of VoCs was such that it was no longer relevant to simply confirm the presence of a specific variant (i.e., until it became as likely or more likely that a positive sample would be related to a VoC than to the original SARS-CoV-2 strain).
- The LDT was an inexpensive, non-complex test with a 24-48 hour turnaround from sample preparation to data generation that made it possible to quickly detect the most prevalent VoCs without waiting for WGS data; however, the lab developed test could not readily identify new variants of the virus.
- Samples that tested positive (presumed positive) for a known VoC were sent to BCCDC PHL where WGS made it possible to confirm the viral lineage, identify transmission clusters and sources of ongoing transmission, and identify new mutations or variants.
- As VoCs became the dominant strains of COVID-19 in BC, there was limited value in confirming the presence of a known variant and a greater need to identify the specific variant, its lineage, its transmission through the community and the potential for virus escape. In addition, as vaccination rates increased, it became important to monitor how the virus and its variants behave in a vaccinated population.
- With the increase in vaccination rates and subsequent decline in positive cases of COVID-19, it was feasible for BCCDC PHL to perform WGS on all positive samples. On May 7, 2021, the Provincial Health Officer supported the proposal for WGS to be performed on all positive samples and (with the exception of St Paul's Hospital Laboratory) Regional Health Authority labs discontinued lab-based testing for VoCs on May 31, 2021.
- At this time, sequencing of all positive COVID-19 samples at BCCDC PHL are being used to:
    - Provide surveillance for emergence of new variants which may feature increased transmissibility, evasion of immune response, or novel clinical manifestations/disease severity.
        - Surveillance requires integration of data from large data sets (provincially and nationally) for interpretation. Having access to centralized data at BCCDC PHL is critical for effective surveillance.
        - Border surveillance (both land and air) are key to monitoring VoC introductions from outside of the province or Canada.
    - Provide information about patterns of transmission in the community.
        - e.g. is an outbreak in a health care facility ongoing or has there been a subsequent introduction of a new variant into the facility?
    - Assess vaccine effectiveness in individuals previously infected with VoC or other lineages.
    - Manage acute care outbreaks.
        - During an outbreak, the unit(s) involved are closed to admission. If patients and/or staff without a clear epidemiological link to the outbreak become positive during prevalence screens, it will extend the outbreak state unless their particular strain can be shown to be unrelated to the outbreak.

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

- Variants arise as a normal phenomenon, through routine mutation of the viral genome. VoC represent variants that appear to have greater transmissibility, potentially greater virulence, and may be less likely to be protected by some of the existing vaccines.
- Three VoCs are currently the focus of attention in BC, originating in the UK (B.1.1.7), Brazil (P1), and India (B.1.617.2). All have mutations in the S protein of the virus, which is the viral binding site with the ACE2 receptor on human cells. Mutations in this protein can alter virus-cell binding and could potentially interfere with binding of neutralizing antibodies generated after vaccination.
- Although these variants are named as having originated in specific geographic areas, the mutations can also arise in Canada and similar variants have been detected in BC, although their impact is not yet understood.
- WGS is expensive due to the costs of reagents, labour and the required informatics infrastructure; however, because the same amount of reagent is required to sequence one sample as to sequence twenty samples, there are significant savings to be had through economies of scale.

## FINANCIAL IMPLICATIONS

The financial impact for fiscal year 2020/21 is not available at this time.

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**Approved:**

June 7, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 7, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
June 10, 2021 – Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Diabetes Supply Policy

### TOPIC

An overview of PharmaCare's diabetes supply coverage policies.

### CURRENT SITUATION

- Diabetes is a serious health problem that is growing worldwide. At the start of 2019, Diabetes Canada estimated that 478,300[1] people, or 9.4%[1] of the population in BC, had diabetes.
- On September 26, 2019, the BC Health Technology Assessment Committee (HTAC) provided a recommendation to the Ministry regarding coverage for continuous and flash glucose monitors. PharmaCare has now completed a review of the devices, consultations with diabetes specialists and relevant stakeholders, and a Competitive Value Process with the manufacturers of the continuous and flash glucose monitors. A listing decision to provide PharmaCare coverage for the Dexcom G6 continuous glucose monitor (CGM) is expected in June 2021. (See also Fact Sheet "Continuous and Flash Glucose Monitors").
- Diabetic foot ulcers are a common and serious diabetes-related complication resulting from chronic high blood sugar; a large number result in amputation of a patient's foot or limb due to infection. Offloading devices relieve pressure on foot ulcers to help them heal and reduce the risk of amputation.
- The HTAC has also conducted a review of the evidence on the effectiveness of offloading devices and on October 29, 2020 submitted its recommendations to the Ministry regarding public coverage. The program area is reviewing the recommendations.

### KEY FACTS

Insulin Pump Coverage/Supplies

- On July 3, 2018, PharmaCare extended insulin pump coverage to British Columbians of all ages. Previous coverage was limited to people under 25 years (from April 1, 2014) and under 19 only (November 17, 2008).
- To access coverage, a person's endocrinologist or physician specializing in diabetes must request pre-approval.
- Eligible patients are granted Special Authority (SA) coverage for a Tier 1 device, currently available at no cost to the recipient regardless of their PharmaCare plan or deductible. Patients with exceptional clinical conditions who require treatment with a Tier 2 device may be eligible for exceptional SA coverage. The cost of the Tier 2 device is subject to the person's Fair PharmaCare deductible and family maximum.
- Coverage is provided for 1 insulin pump every 5 years.
- Insulin pumps range in cost from $6,000 to $7,000 and last for approximately 5 years.
- PharmaCare also covers insulin pump infusion sets, pods, and reservoirs/cartridges for BC residents, regardless of the type of pump they use or if that pump was covered by PharmaCare.
- PharmaCare covers the rapid-acting insulins used in insulin pumps, up to a maximum allowable cost that aligns with the lower cost of regular insulin.

Blood Glucose Test Strips

- PharmaCare provides coverage for Blood Glucose Test Strips (BGTS) to patients with diabetes who need to test and who have received a certificate of training from an accredited Diabetes Education Centre (DEC). In lieu of obtaining a certificate from a DEC, patients covered under PharmaCare Plan W (First Nations Health Benefits) may contact the First Nations Health Authority to have BGTS coverage activated.
- On January 1, 2015, the Ministry introduced a limits to the quantity of BGTS reimbursed by PharmaCare. These limits are based on 4 categories of patients and are in line with those recommended by Diabetes Canada (see also BGTS-Coverage Limits). A 5th category will be added once PharmaCare coverage for a CGM is provided; it will set a specific limit on the quantity of BGTS reimbursed by PharmaCare for patients using a CGM.
- The cost of BGTS is reimbursed at the actual acquisition cost up to the existing PharmaCare maximum cost that is based on the manufacturer list price plus 7% plus a dispensing fee.

[1] Data Source: Ministry of Health Chronic Diseases Registry, 2018/19.

# LEGISLATIVE SESSION - FACT SHEET

Policy Development – BGTS Coverage Limits

- In 2009 the Canadian Agency for Drugs and Technologies in Health (CADTH) released an Optimal Therapy Report[2] on the prescribing and use of BGTS that recommended against routine self-monitoring for patients not on insulin therapy.
- In 2010, the Pharmaceutical, Laboratory, and Blood Services Division developed an educational strategy to promote evidence-informed optimal use of BGTS. The strategy involved a public forum, live presentations, and promotion of print tools and prescribing aids. The key message was that frequent self-monitoring of blood glucose shows limited benefit for most patients with Type 2 diabetes who are not using insulin.
- In 2011, PharmaCare expenditures for BGTS fell by $0.91 million (from $27.30 to $26.39)[3] compared to 2010. This could be attributed to the educational initiative.
- Also, in 2011, the Canadian Journal of Diabetes published a Diabetes Canada (formerly the Canadian Diabetes Association) briefing document[4] that aligned with CADTH's recommendations.
- Following a review of the current BGTS coverage policy and input from key stakeholders at a February 18, 2014, engagement session, the Ministry introduced the new BGTS policy on January 1, 2015.
- PharmaCare spending on test strips in 2020 decreased by $8.14 million[5] as compared to that in 2014.

Glucometers

- Manufacturers of BGTS generally provide glucometers to patients free of charge; a glucometer will usually only read BGTS manufactured by the same company.

Continuous Glucose Monitors

- PharmaCare is currently reviewing the CGMs and flash glucose monitors (FGMs) and is anticipated to begin providing coverage for a CGM, the Dexcom G6, in June 2021.
- The CGM will be a limited coverage benefit, available only to patients with diabetes who meet the SA criteria for a CGM. Initial approval of CGM coverage will be for 1 year and renewals will be for 5 years.
- PharmaCare will cover all components of the Dexcom G6 CGM system, which includes sensors, transmitters, and the optional receiver. The manufacturer of the Dexcom G6 will not be distributing receivers via pharmacies at this time; but patients can choose to acquire a receiver directly from the manufacturer.

Offloading Devices

- PharmaCare is reviewing offloading devices for coverage and anticipates a coverage decision later in 2021 .

## FINANCIAL IMPLICATIONS

- PharmaCare spending for diabetes medication and supplies coverage increased by $4.20 million or 5.5% from 2018/19 to 2019/20 ($76.03 million and $80.23 million respectively).[6]
- In 2019/20 PharmaCare expenditure for insulin pumps was $2.67 million[7], for insulin pump supplies was $6.58 million[8], and for BGTS was $16.86 million[9].

Government Financial Information

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**Approved:**

February 25, 2021 – C. Voggenreiter obo Martin Wright, ADM, ; Health Sector Information, Analysis & Reporting Division
June 3, 2021 - Mitch Moneo, ADM, Pharmaceutical Laboratory and Blood Services Division
June 7, 2021 - Brenda Rafter, obo Philip Twyford, ADM, Finance and Corporate Services Division

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[2] CADTH. Optimal Therapy Recommendation for the Use of Solvent/Detergent-Treated Human Plasma. *CADTH Technology Overviews, Volume 2, Issue 3, e2202 August 2012.* Retrieved electronically on December 20, 2013 from: http://www.cadth.ca/en/products/cadth-overviews/overview-volume-2/2
[3] PharmaNet data, Health Sector Information, Analysis and Reporting, September 4, 2020.
[4] Canadian Diabetes Association (September 2011). Self-monitoring of blood glucose in people with type 2 diabetes: Canadian Diabetes Association briefing document for healthcare providers. Canadian Journal of Diabetes (pp.317 – 319). Retrieved June 24, 2013 from http://www.diabetes.ca/documents/for-professionals/CJD--Sept_2011--SMBG.pdf
[5] PharmaNet data, Health Sector Information, Analysis and Reporting, February 10, 2021.
[6] PharmaNet data, Health Sector Information, Analysis and Reporting, September 4, 2020.
[7] PharmaNet data, Health Sector Information, Analysis and Reporting, September 4, 2020.
[8] PharmaNet data, Health Sector Information, Analysis and Reporting, September 4, 2020.
[9] PharmaNet data, Health Sector Information, Analysis and Reporting, September 4, 2020.

# LEGISLATIVE SESSION - FACT SHEET

## Drug Shortages

### TOPIC

- Drug shortages are a national and international issue. Shortages occur when a manufacturer or distributor of a generic or a brand name drug is unable to meet demand.
- Shortages can include temporary production and supply disruptions or permanent discontinuations. They may arise from a number of possible causes, including production issues, problems with sole source contracting, unexpected surges in demand, difficulties accessing raw materials, quality control issues resulting in the recall of substantial lots, or Health Canada regulatory action (e.g., importation bans).
- Drug shortages, if not managed appropriately, can have a negative impact on patients, health care professionals, the health care system and the drug product supply chain.

### CURRENT SITUATION

- More extreme critical drug shortages have occurred since the start of the COVID-19 pandemic due to the increased demand on some drugs for COVID-19 treatment, the availability of Active Pharmaceutical Ingredients, global transportation and production issues. Various mitigation strategies have been put in place to manage drug shortages ensuring shortages do not impact patient care and patient safety.
- The pan-Canadian Pharmaceutical Alliance Governing Council discussed drug shortages at the March 27, 2020 meeting and agreed it would be advantageous to work with Health Canada on issues related to drug supply, shortages, and allocation of drug products related to the COVID-19 pandemic. The creation of the Federal, Provincial and Territorial (FPT) ADM Drug Shortages Table and the FPT Drug Shortages Task Force was endorsed by Deputy Ministers of Health (DMs) on April 20, 2020, to address COVID-19 drug supply issues including the development of an allocation framework. The collaborative work of the Health Canada Drug Shortages Unit, the PT Drug Shortages Task Team (PT DSTT) and the BC Pharmaceutical Supply Chain Subcommittee also contributes to the management of drug shortages.
- The Framework for the Effective Management of Drug Supply in the Context of the COVID-19 Pandemic guides the allocation of foreign supply to address Tier 3 drug shortages in Canada as well as the newly established national reserve of federally procured drugs known as the critical drug reserve.
- The Government of Canada has taken additional steps to prevent and alleviate the shortages caused directly or indirectly from the COVID-19 pandemic. In March 2020, the federal Minister of Health signed an Interim Order that allows products (i.e. drugs, medical devices and foods for special dietary purposes) that are not approved in Canada but manufactured with similar standards, to be imported and sold in Canada subject to certain requirements. This followed legislative amendments made to the *Food and Drugs Act* that enabled Health Canada to put in place more robust tools to support efforts to help prevent and alleviate shortages.
- As of May 25, 2021, there are 565 reported drug shortages in the BC community supply chain which includes 300 drugs that are discontinued by the manufacturer .[1] This number may include multiple dosages of the same drug if they are all in short supply.
- The Ministry continues to participate in various national, provincial and Ministry drug shortages task groups/committees along with BC Health Authority representatives.

### KEY FACTS

**At Federal Level:**

- Health Canada is responsible for assessing the safety, efficacy and quality of drugs and other health products on the Canadian market. In their role as federal regulator they can request voluntary quarantines, stop sales, and impose import restrictions or product recalls.[2]
- 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.

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[1] http://www.health.gov.bc.ca/pharmacare/drug-shortage/drugshortageupdate.xls, accessed on May 26, 2021.

[2] See http://www.hc-sc.gc.ca/dhp-mps/pubs/compli-conform/tracker-suivi-eng.php

- 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 in manufacturing processes or changes in manufacturing locations;
    - working with international counterparts to identify additional sources of supply;
    - providing the health system with priority access to non-marketed alternatives on an emergency basis via the Special Access Program; and
    - employing an expedited review process to expedite the review of another drug.
- In 2016, Health Canada introduced regulations which requires mandatory reporting by drug manufacturers of all drug shortages and discontinuations on the website: www.drugshortages.ca.
- In 2017, Health Canada launched the Inspection Tracker reporting system, which provides notification and information on actions Health Canada is taking on concerns associated with the manufacturing of drugs intended for the Canadian market. The actions include voluntary quarantine of the drug supplies, stopping the sale of the drugs, initiating importing restrictions or recalls.
- In 2012, the FPT DMs emphasized the importance of improving drug shortage information and communication and endorsed the Multi-Stakeholder Steering Committee on Drug Shortages (MSSCDS) made up of industry and health care representatives to address drug shortages.
- The MSSCDS collaborates to improve the communication on drug shortages to the public and to develop enhanced strategies for the prevention and mitigation of drug shortages. The MSSCDS has developed some key tools such as a Multi-Stakeholder Toolkit and a Protocol for the Notification and Communication of Drug Shortages.
- In 2012, the Provincial/Territorial Drug Shortages Task Team (PT DSTT) was formally established by the PT DMs. Made up of representatives from all P/T Health Ministries, group purchasing organizations and regional health authorities, it has a mandate to identify, prevent, alleviate and resolve drug shortage situations.
- As of April 2021, BC began a two-year term as the chair of PT DSTT and as the co-chair of the MSSCDS.

**At Provincial Level:**

- 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.
- The Ministry actively works with other provinces and territories, Health Canada, BC's health authorities, Health Insurance BC (HIBC), health professional associations and the Colleges to manage shortage situations. This includes participation in the provincial Pharmaceutical Supply Chain Subcommittee that mitigates drug shortages at the community and acute care level in BC.
- These collaborative proactive actions have been effective in minimizing drug shortages and potential patient care impacts in BC.
- In March 2015, the Ministry launched a Drug Shortages web page[3] 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. HIBC manages the web page for the Ministry.
- In February 2021, the Ministry hired a full-time pharmacist to support the provivincal and national commitments for drug shortages.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
May 31, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

[3] See https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/pharmacies/drug-shortage-information

# LEGISLATIVE SESSION - FACT SHEET

## Drugs Under Review

### TOPIC

- PharmaCare is the provincial program responsible for providing financial assistance for eligible prescription drugs and designated medical supplies.
- To ensure our services are sustainable, fair and effective, the Ministry of Health requires all drugs undergo a rigorous, scientific review process.
- If the review process determines a drug has therapeutic advantages and cost-effectiveness advantages over established treatments, the Ministry considers adding the drug to the PharmaCare program formulary (a list of drugs eligible for coverage).

### CURRENT SITUATION

- As of June 14, 2021, the Ministry has 85 active drugs under review, and the national Common Drug Review (CDR) has 72 drugs under review or queued that are not yet under review by the Ministry. [1]
- As of June 14, 2021, the pan-Canadian Pharmaceutical Alliance (pCPA) is negotiating prices with manufacturers for 38 drug products, some of which are also under review by the Ministry.[2]

### KEY FACTS

- The Ministry makes PharmaCare coverage decisions by considering existing PharmaCare policies, programs, priorities and resources, and the evidence-informed recommendations of an independent advisory body called the Drug Benefit Council (DBC).
- The DBC's advice to the Ministry is based upon a review of many considerations, including: available clinical and pharmacoeconomic evidence (pharmacoeconomics is the branch of economics which compares the value of drugs); clinical practice and ethical considerations; input from patients, caregivers and patient groups provided through the Ministry's *Your Voice* webpage; and the recommendations of the national CDR.
- The Ministry may also participate in the pCPA negotiations with the manufacturer if applicable and considers the outcomes of the pCPA's negotiation when making a listing decision for the drug.
- As of June 14, 2021, 72 drugs are under review or queued at the CDR. This number is subject to change as reviews are completed and new submissions are received. Examples include:
    - dupilumab (Dupixent) for asthma;
    - romosozumab (Evenity) for osteoporosis in postmenopausal women;
    - fedratinib (Inrebic) for myelofibrosis;
    - risperidone (Perseris) for schizophrenia in adults;
    - budesonide (Jorveza) for the maintenance of eosinophilic esophagitis in adults; and
    - luspatercept (Reblozyl) for myelodysplastic syndromes-associated anemia.
- As of June 14, 2021, there are 38 negotiations active with the pCPA. Not all of these drugs may be eligible for PharmaCare coverage, as the pCPA also negotiates for cancer drugs that are covered by the BC Cancer Agency, transplant drugs that are covered by BC Transplant, and drugs for the treatment of HIV infection that are covered by the BC Centre of Excellence in HIV/AIDs. Drugs that are potential PharmaCare benefits that are under pCPA review include the following:
    - teriparatide (Osnuvo) for osteoporosis;
    - onabotulinumtoxin a (Botox), fremanezumab (Ajovy) and erenumab (Aimovig) for chronic migraine;
    - onasemnogene abeparvovec (Zolgensma) for spinal muscular atrophy; and
    - ustekinumab (Stelara) for ulcerative colitis.
- As of June 14, 2021, 85 drugs are under review at the Ministry. The following are examples of drugs under review for which pCPA negotiations are completed:
    - teduglutide (Revestive) for short bowel syndrome;
    - isavuconazole (Cresemba) for invasive aspergillosis and mucormycosis.

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[1] Source: https://cadth.ca/about-cadth/what-we-do/products-services/cdr/reports

[2] Source: https://www.pcpacanada.ca/negotiations

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

Most new drugs represent an incremental cost impact to the BC PharmaCare program. Therefore, they must be carefully reviewed, and their prices negotiated to ensure the long-term sustainability of BC PharmaCare.

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**Approved:**

February 1, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
June 14, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Expensive Drugs for Rare Diseases

### TOPIC

- Expensive Drugs for Rare Diseases (EDRD) present a host of complex challenges as these drugs are prohibitively expensive, often have limited clinical evidence to support their use, and benefit only a small number of patients.
- The Ministry of Health is co-leading a Provincial Territorial (PT) Working Group on EDRDs with Alberta and Ontario. The Ministry of Health is also co-leading a Federal High Cost Drugs for Rare Diseases (HCDRDs) Sub-Working Group [updated].

### CURRENT SITUATION

- Because of the rarity of the diseases, drugs being developed often do not have strong clinical evidence supporting their efficacy and/or safety. Study limitations may include few patients or short-term follow-up. Most EDRDs have only demonstrated to slow non-clinical or surrogate endpoints (e.g., lab test or physical performance result) rather than an increase in survival or cure.
- Since 2014, the PT Health Ministers established the PT EDRD Working Group to explore the management of rare disease drug therapies with evidence-based approaches. BC, Alberta and Ontario co-lead this working group and provide periodic updates to the Health Ministers. The working group is exploring managed access or funding with evidence development models in collaboration with Alberta's Institute of Health Economics, a supplemental approach with public health partners to improve the national management of these complex drugs.
- As of June 2021, 117 patients are on one of the 24 EDRDs funded by the Ministry on an exceptional, last-resort, case-by-case basis [updated].
- Since the beginning of the 2021/22 fiscal period, four additional EDRD therapies are now considered for exceptional case-by-case funding: patisiran (Onpattro), inotersen (Tegsedi), tafamidis (Vyndaqel) and lanadelumab (Takhzyro) [updated].
- Noteable cost-drivers for the 2021/22 fiscal year include [updated]:
    - High-volume EDRDs, such as Trikafta for the treatment of Cystic Fibrosis. It is estimated that 300 patients will be eligible for Trikafta this fiscal period. In addition, it is estimated that 50 patients will receive funding for tafamidis in that same time-frame.
    - Gene therapies, such as Zolgensma, which are significantly more expensive despite lower incidence rates. For example, the list price of Zolgensma is $2.9M.
    - There are several new EDRD therapies entering the Canadian market. The Ministry is currently in active negotiations for burosumab, eculizumab for two indications, and satralizumab.

### KEY FACTS

- 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., >$100,000 per patient). The pharmaceutical manufacturers are now increasingly setting very high prices for more prevalent rare conditions (e.g., 1 in 4000).
- The *Canada Health Act* does not include coverage of drugs. Drug coverage including EDRDs may vary among provinces and definitions of "rarity" differ among countries.
- Companies developing such drugs usually price their products very high, arguing they need to recoup their development costs from a small market, but do not provide any transparency to justify such prices. The products are typically priced far beyond any individual or family's ability to pay.
- 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. However, the Ministry may consider exceptional last-resort funding requests for certain drugs on a case-by-case basis.
- The Ministry utilizes a review process for exceptional 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 ethisist, 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 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 (PHSA) to administer the exceptional EDRD advisory committee process.

**PT and FPT Activities**

- In April 2013, Health Canada began consultation regarding a new Orphan Drug Regulation, intended to improve market access to drugs for rare diseases. The Ministry provided feedback to Health Canada in January 2014. In May 2017, Health Canada advised they are working on a new regulatory roadmap for orphan drugs in lieu of the previously proposed regulation. The regulatory roadmap will be part of the new Health Canada transformation initiative for all drugs (not necessarily specific to orphan drugs).
- On March 19, 2019, the federal government released its 2019 budget, which called for a national strategy for high-cost (expensive) drugs for rare diseases (EDRDs) and committed to spending $500 million per year starting in FY 2022/23. The federal government proposed to work with the provinces and territories to develop a plan to ensure that patients with rare diseases have better and more consistent coverage of EDRDs across the country. In December 2020, they issued a draft engagement, and consultation plan as next steps to facilitate further discussion on the national high-cost drugs for rare diseases strategy. The PT engagement is ongoing and BC has been actively involved in their consultation.
- In August 2019, the federal government announced new regulations to provide the Patented Medicine Prices Review Board (PMPRB) with new tests to better protect Canadians against excessive drug pricing. For the external price reference test, the list of countries used for international price comparisons will be revised to better reflect the Canada health care system. In addition, new test factors were added to determine whether the price of medicines is excessive. These new factors include pharmacoeconomic value, the size of the market for medicines, and gross domestic product. These changes were expected to come into effect on January 1, 2021, but have subsequently been delayed to July 1, 2021.
- Health Canada is continuing to develop their National Strategy for HCDRDs. This includes discussions with Assistant Deputy Ministers from Ministries of Health across Canada who form the FPT Pharmaceuticals Executive Group and discussions with Executive Directors, Directors and staff from various Ministries who form a sub-working group. This sub-working group is co-chaired by Health Canada and BC. Members of the subworking group provide Health Canada with feedback regarding various potential governance structures, allocations of funds and complexities associated with HCDRDs [updated].

## FINANCIAL IMPLICATIONS

- The EDRD expenditures were $36.2 million in 2020/21, $32.1 million in 2019/20, $24.4 million in 2018/19, $22.4 million in 2017/18, and $17 million in 2016/17. These costs do not factor in any confidential agreements the Ministry may have signed with manufacturers of EDRDs.
- It is forecasted that the EDRD expenditures will reach $112 million in the 2021/22 fiscal year, with 520 British Columbians receiving funding for one of these therapies. The recoveries from the confidential agreements with EDRDs manufactures and the savings from the biosimilars that are replacing expensive drugs will substantially offset these expenditures. [updated].
- Based on list prices, the annual treatment cost for EDRD drugs per patient may range from over $100,000 to over $3 million, depending on the drug, weight of the patient, and dosing regimen.

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**Approved:**
June 14, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory & Blood Services Division
June 14, 2021 – Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Fair PharmaCare

### TOPIC

Fair PharmaCare is BC's income-based drug plan. This plan covers the majority of BC residents who are eligible for PharmaCare benefits and offers assistance based on family net income.

### CURRENT SITUATION

- Total registration for Fair PharmaCare has grown each year since 2003. As of the end of 2019/20, nearly 1.3 million families were registered.[1]
- The Pharmaceutical, Laboratory and Blood Services Division encourages British Columbians to register for Fair PharmaCare by:
  - Distributing Fair PharmaCare information to pharmacies, Service BC Centres, employment/income assistance offices, health fairs and mental health service centres in BC.
  - Making Fair PharmaCare brochures available in English, Arabic, Spanish, Punjabi, Chinese (Simplified and Traditional), French, Farsi, Korean, Vietnamese and Filipino.
  - Adding Fair PharmaCare brochures to MSP application kits.
- In 2019/20, Fair PharmaCare helped approximately 520,000 British Columbians with the purchase of roughly 15.9 million prescriptions.[1]
- The Minister of Health's 2020 mandate letter includes a directive to "Fight for a national pharmacare program while enhancing Fair PharmaCare by continually reviewing cost thresholds and drug eligibility with the goal of bringing the cost of prescription drugs down".

Fair PharmaCare Enhancements

- On February 9, 2018, the Ministry announced that $105 million would be invested in Fair PharmaCare over 3 years.
- The investment reduces or eliminates deductibles and family maximums for approximately 240,000 lower income families, effective January 1, 2019.
- Effective January 1, 2019, all families with net annual incomes between $15,000 and $30,000 are no longer required to pay a deductible. With a $0 deductible, their eligible drug costs are 70% paid by PharmaCare, until their drug costs reach their family maximum, after which point PharmaCare pays 100% of eligible costs.
- Co-payments have been eliminated for families covered under Enhanced Assistance with a net income of up to $14,000 and for regular assistance families with a net income of up to $13,750.
- Co-payments have also been lowered for all families, including seniors, with net incomes of up to $45,000.
- Impact of the Enhancements, in the calendar year 2019:
  - 79,718 families earning up to $45,000 received PharmaCare-paid benefits who would not have received a paid benefit prior to the 2019 Fair PharmaCare Enhancements.[2]
  - 215,546 families earning up to $45,000 had an increase in their PharmaCare-paid benefits as a result of the 2019 Fair PharmaCare Enhancements.[3]
  - As a part of the mandate to integrate Gender Based Analysis Plus (GBA+), the analysis included a demographic breakdown. Single women (52%) earning up to $45,000 benefitted most from the Fair PharmaCare Enhancements.[4]
- Further evaluation of these changes is ongoing and will inform future opportunities to enhance Fair PharmaCare, as directed by the 2020 mandate letter.

### KEY FACTS

- Introduced on May 1, 2003, Fair PharmaCare is BC's universal, income-based drug insurance plan. Individuals have a $10,000 deductible until they register for income-based coverage.

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[1] PharmaNet, Health Sector Information, Analysis and Reporting, June 26, 2020.
[2] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, June 26, 2020
[3] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, June 26, 2020
[4] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, June 26, 2020

- A simulation of the impact on BC residents showed that when originally introduced, over 300,000 BC families were made better off by the introduction of Fair PharmaCare.[5]
- To be eligible for Fair PharmaCare assistance: an individual must be a resident of BC; have medical coverage under the BC Medical Services Plan; have a Social Insurance Number; and file income taxes in Canada.
- Families may register for Fair PharmaCare by contacting Health Insurance BC (HIBC), administrator of PharmaCare programs, via phone, mail, fax, or the PharmaCare website.
- Fair PharmaCare income-based financial assistance is based on 3 elements, which are calculated as a percentage of family net income:
  - Deductible: families are responsible for all drug costs until they reach their deductible.
  - Co-payment: after a family has reached its deductible, further drug expenditures are shared between PharmaCare and the family, with PharmaCare paying the larger portion.
  - Family maximum: the maximum amount a family will pay toward eligible drug costs in a year. Eligible benefit costs above the family maximum are 100% paid by PharmaCare.
- Families with one or more members born before 1940 receive enhanced assistance, which is more generous than regular Fair PharmaCare benefits and was introduced to mitigate the impact of the change in 2003 from an age-based plan to an income-based plan.
- Families experiencing a 10% or more reduction in income in the past two years may request adjustment of their deductible/family maximum through HIBC.

## FINANCIAL IMPLICATIONS

- On February 9, 2018, the Ministry announced that $105 million would be invested in Fair PharmaCare over 3 years.
- The total increase in Fair PharmaCare expenditures attributable to the Fair PharmaCare Enhancement for the 2019 calendar year was $31.6 million.[6] Calendar 2020 expenditures have not been finalized.

**Fair PharmaCare - Utilization and Expenditure Statistics (millions) [1]**

| | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 | 2019/20 |
|---|---|---|---|---|---|---|---|---|---|
| Total Fair PharmaCare Expenditures | $579.18 | $567.34 | $553.65 | $552.80 | $679.66 | $647.66 | $667.71 | $716.64 | $708.17 |
| Number of beneficiaries | 0.57 | 0.55 | 0.52 | 0.50 | 0.48 | 0.46 | 0.43 | 0.47 | 0.52 |
| Total PharmaCare Expenditures[7] | $1,109.80 | $1,100.88 | $1,076.15 | $1,078.99 | $1,171.63 | $1,202.20 | $1,214.24 | $1,224.49 | $1,233.15 |

**Approved:**
January 27, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
January 28, 2021 – C. Voggenreiter, obo Martin Wright, ADM, Health Sector Information Analysis and Reporting Division
February 17, 2021 - Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division

[5] PSD simulated the Fair PharmaCare claims adjudication for 2004 under the 2001 policy rules, using PharmaNet data in 2005.
[6] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, June 26, 2020
[7] Corporate Finance, Ministry of Health.

# LEGISLATIVE SESSION - FACT SHEET

## Federal Genetic Non-Discrimination Act

### TOPIC

The federal *Genetic Non-Discrimination Act* (Act*)* received Royal Assent on May 4, 2017. The Act amends the *Canadian Human Rights Act* (CHRA) and *Canada Labour Code* (CLC) and enacts criminal penalties to prohibit discrimination on the basis of "genetic characteristics."

### CURRENT SITUATION

- BC, Manitoba, and Quebec expressed opposition to the Act on constitutional grounds due to overlap with provincial jurisdictions on insurance, human rights, and labour.
- The Quebec government referred the criminal portion of the Act (ss 1-7) to its Court of Appeal for an opinion on its constitutionality. On December 21, 2018, the Quebec Court of Appeal **found the provisions were unlawful** in that the provisions did not fall within the federal government's criminal powers.
- In October 2019, the Act went to the Supreme Court of Canada (SCC) for constitutional review.
- On July 10, 2020 the SCC released its decision to uphold the Act in its entirety.
- Had the SCC dismissed the appeal, there would have been a vacuum in provincial regulation as the federal legislation amending the CHRA and the CLC would not apply to provincially-regulated fields such as insurance contracts and employment rules for provincially-regulated industries.
- The Ministry of the Attorney General (MAG) is assessing potential impacts to provincial legislation resulting from the SCC decision to uphold the Act.
- The Ministry of Health supports the ongoing work to be conducted by the MAG and will:
    - Assist MAG on health-related topics including health insurance/extended benefits considerations.
    - Continue to monitor issues relating to the Act, including engagement with MAG staff and routine scans of related media releases.

### KEY FACTS

- The Act:
    - Amends the federal *Canadian Human Rights Act* to prohibit discrimination on the basis of "genetic characteristics".
    - Amends the *Canada Labour Code* to prohibit employers from requiring genetic testing, disclosing genetic test results, or discriminating against an employee for not undertaking a genetic test. These changes are limited to areas of federal jurisdiction.
    - Stipulates that a person must not require an individual to undergo a genetic test or to disclose the results of a genetic test as a condition of entering into or continuing a contract or agreement with that individual. This prohibition is intended to apply to all contracts, including insurance contracts.
    - Prohibits the collection, use or disclosure of results of genetic tests of an individual without the individual's written consent.
    - Provides broader criminal penalties to prohibit the requirement of a genetic test when entering into contractual arrangements.
    - Physicians, pharmacists, or health care practitioners providing health services, or persons providing medical, pharmaceutical or scientific research are exempted from the Act.
- The Canadian Life and Health Insurance Association, which represents life insurance companies in Canada, expressed opposition to the federal Act. They maintained that genetic test results are required to ensure the sustainability of the insurance market.
- Canadian Health Insurance companies have engaged, and continue to engage, with private companies to obtain and use genetic data of Canadians, including British Columbians, which may be contrary to the Act.[1],[2]

[1] https://bit.ly/3caLiTB
[2] https://bit.ly/2YckGt5

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

Financial implications will be identified once the BC's Ministry of Attorney General has completed assessment of the impacts of the federal Act.

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**Approved:**
January 27, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

# First Nations Health Benefits (Plan W)

## TOPIC

The First Nations Health Benefits Plan (Plan W) provides PharmaCare coverage for clients of the First Nations Health Authority (FNHA). This is a first-of-its-kind provincial First Nations drug benefits plan, leveraging provincial systems where possible, and setting a precedent for the rest of Canada.

## CURRENT SITUATION

- On October 1, 2017, FNHA clients joined the BC PharmaCare program. On that date, most FNHA clients who had previously been receiving benefits through Health Canada's Non-Insured Health Benefits (NIHB) program became eligible for Plan W.
- FNHA is actively working on enrolling in Plan W these remaining clients who have not yet been enrolled.
- In addition, some benefits were not transitioned to PharmaCare, including some Medical Supplies and Equipment (MS&E) requiring pre-approval by NIHB, and some prescription medications. From October 1, 2017 until September 16, 2019, FNHA clients continued to receive NIHB coverage for this residual/supplemental formulary; as of September 19, 2019, the residual/supplemental formulary was transitioned to Pacific Blue Cross (PBC). Claims for these benefits, as well as claims for FNHA clients who are not enrolled in Plan W, are now adjudicated by PBC.

## KEY FACTS

- Under Plan W, PharmaCare pays 100% of:
    - eligible prescription drug costs up to the maximum cost recognized by PharmaCare;
    - certain over-the-counter medications;
    - eligible medical supply/device costs, except MS&E items that required NIHB pre-approval;
    - dispensing and pharmacy services fee costs up to the maximum fees recognized by PharmaCare; and
    - Plan W benefits purchased within Canada but outside BC if a request for reimbursement is submitted with appropriate documentation.
- All FNHA clients continue to be eligible for coverage under other PharmaCare plans.
- Plan W is not income tested or income-based and no deductibles or family maximums apply.
- Plan W coverage is available to an individual if they:
    - have active Medical Services Plan (MSP) coverage;
    - are a registered Indian under the *Indian Act*, or are a child of less than 24 months of age who has at least one parent who is a registered Indian under the *Indian Act*; and
    - are not an individual who is eligible to receive comprehensive drug coverage through a:
        - treaty and land claims agreement under the *Constitution Act, 1982* (Canada) (unless that treaty and land claims agreement has been identified by the provincial Minister of Health as not resulting in ineligibility); or
        - written contribution arrangement between a First Nations organization and a government or province of Canada under which the government provides funding and which has been identified by the provincial Minister of Health as resulting in ineligibility for enrolment.
- The FNHA confirms eligibility and Plan W coverage is automatically uploaded to PharmaNet. Coverage is in effect from the time the individual's eligibility for Plan W is uploaded to PharmaNet. Plan W coverage cannot be provided retroactively.
- Most FNHA clients were automatically enrolled in Plan W on October 1, 2017. Any remaining individuals who are eligible for Plan W can transition to Plan W as desired.
- The Plan W formulary differs slightly from the former NIHB formulary. Most prescriptions for FNHA clients continued to be covered automatically through PharmaCare, but some clients needed to change to a different product to access full coverage. Some other clients found they were able to switch to a drug product under the PharmaCare formulary that was not an NIHB benefit.
- PharmaCare granted Special Authorizations to FNHA clients to ensure the same level of coverage that was being provided through NIHB would be provided through Plan W.

- For continuity of care, PharmaCare Plan W also covers most over-the-counter (OTC) medications previously covered under the NIHB formulary, with some modifications to align with PharmaCare's Low Cost Alternative policy.
- FNHA and Pharmaceutical, Laboratory and Blood Services Division staff meet regularly through Steering and Management Committees to steer the administration of Plan W.

## FINANCIAL IMPLICATIONS

Government Financial Information

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**Approved:**

February 18, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
June 17, 2021 - Christine Voggenreiter obo ADM Martin Wright, Health Sector Information, Analysis and Reporting
June 17, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

[1] PharmaNet, Health Sector Information, Analysis & Reporting Division, June 17, 2021

# LEGISLATIVE SESSION - FACT SHEET

## Free Prescription Contraception Coverage

### TOPIC

The Ministry of Health recognizes the right of all BC residents to make and implement informed choices about their sexual and reproductive health. In recognition of this right, the 2020 Minister of Health Mandate Letter includes a commitment to "make prescription contraception free for all" BC residents.

### CURRENT SITUATION

- The Ministry is working with internal and external partners on a phased plan to implement the mandate letter commitment and ensure that all BC residents can equitably access and benefit from free prescription contraception.

Advice/Recommendations

- The transition of benefits to Plan Z would make prescription contraception free for BC residents. Further analysis and planning is under way to explore how to implement the mandate for free prescription contraception in a way that meets the general mandate for equality and anti-racisim, to ensure equitable service delivery of this benefit across the province.

### KEY FACTS

- Offering free prescription contraception to all BC residents supports a range of population health benefits, including decreasing unintended pregnancies and hysterectomies, as well as increasing accessibility of gender-affirming hormone treatments. Providing coverage for a wide range of contraceptive options allows residents to access the method that best suits their needs, which improves access to culturally safe, trauma informed care.
- Unintended pregnancy is common in BC where 40% of pregnancies, including one third of all births, are unintended at the time of conception.[1]
- Cost has been identified as the main barrier to accessing prescription contraception in BC.[2]
- Additional barriers include lack of access to the full range of contraceptive methods available in Canada, lack of culturally safe, trauma-informed and gender-affirming contraceptive care, and/or lack of access to a trained contraceptive provider close to home.
- PharmaCare is the provincial program responsible for providing financial assistance for eligible prescription drugs and designated medical devices and supplies. All BC residents have access to pharmaceutical coverage under the universal, income based Fair PharmaCare plan. Fair PharmaCare only contributes to the cost of eligible medications after a family has paid their annual deductible.
- Currently, and prior to implementation of free prescription contraception coverage, PharmaCare covers some oral contraceptives, certain hormonal intrauterine devices (IUDs) and hormonal intrauterine contraceptives, and an injectable product as regular benefits under Fair PharmaCare, for recipients of Social Assistance (Plan C), and under Plan W. Additionally, some non-hormonal copper IUDs are covered only for FNHA clients under Plan W.

Advice/Recommendations

[1] https://med-fom-cart-grac.sites.olt.ubc.ca/files/2020/12/2015-BC-Sexual-Health-Indicators-CART-CSHS_2017-06-15.pdf
[2] https://med-fom-cart-grac.sites.olt.ubc.ca/files/2020/12/2015-BC-Sexual-Health-Indicators-CART-CSHS_2017-06-15.pdf

Advice/Recommentations

## FINANCIAL IMPLICATIONS

- In FY 2020/21, PharmaCare paid $3.79 million in drug cost and dispensing fees for contraceptives ($2.56 million on hormonal contraceptives and $1.23 million on IUDs).

Advice/Recommentations

- If coverage is to be provided through PharmaCare in a manner similar to Mifegymiso, PharmaCare's pricing policies would apply, and in particulat the Lowest Cost Alternative policy for generic drug pricing would apply providing full coverage of the generic versions of a drug when available, and coverage of brand name products up to the price of the equivalent generic.

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**Approved:**
February 9, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 16, 2021 – Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
June 14, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Gene Therapies – CAR T-cell Therapies

## TOPIC

Advances in modern medicine have created new gene and cellular therapies for specific cancers. One such therapy called Chimeric Antigen Receptor T-cell (CAR-T) therapy has the potential to be a life-saving treatment for specific cancers when other treatments have failed.

## CURRENT SITUATION

- Health Canada approved multiple therapies, including two that treat leukemia/lymphoma (KYMRIAH and YESCARTA) and one that treats multiple myeloma (ABECMA).
    - An additional 20 gene therapies up to June 2020 have already been approved by other jurisdictions (US Food and Drug Administration and/or European Medicines Agency)[1], and it is expected that more than 40 new gene therapies will be approved by Health Canada over the next two to three years for cancer, rare, ultra rare, and common/chronic diseases.[2]
- CAR-T therapy is a complex therapy with significant life-saving potential for specific cancers. In CAR-T therapy, a patient's T-cells (a white blood cell) are harvested and genetically modified to recognize, bind to, and kill cancerous cells.
    - In Fall 2019, Ontario and Quebec publicly announced access and national capacity for pediatric patients, with very limited capacity for adult patients.
    - Throughout the COVID outbreak of 2020, access to CAR-T was partially disrupted, and expanded access across Canada was slower than expected.

**BC Patients Access to CAR-T Therapy:**

- Funding for CAR-T treatment is currently managed through the Medical Services Plan (MSP) Out-of-Country (OOC) program.
- Since 2017 to present, the MSP OOC program, working with the Leukemia/Bone Marrow Transplant (L/BMT) program, approved 23 patients to receive CAR-T therapy OOC.[3]
- BC pediatric and adult patients have had access to KYMRIAH in both Ontario and Quebec since late 2019, however, capacity for adults has been limited at these jurisdictions to accept Out-of-Province (OOP) patients. Eligible BC patients continue to access CAR-T through OOC treatment options, specifically Seattle WA and will soon be able to obtain access within Canada through OOP mechanisms.
- BC patients have also been able to access CAR-T through variousclinical trials at Vancouver General Hospital.

**National Coordination of Pricing and Hospital Capacity for CAR-T:**

- In early 2018 an Ad-Hoc Federal, Provincial and Territorial Committee (Ad Hoc Committee) was created to develop a coordinated pan-Canadian approach to assess and establish CAR-T products for potential public funding. The Ministry of Health's Precision Medicine and Genetic Services unit represents BC on this committee.
- The Ministry has been working with the Provincial Health Services Authority on CAR-T implementation as part of a broader BC Cancer Strategy for British Columbians.

## KEY FACTS

- Gene therapy is an emerging area of precision medicine where genetic material is administered to modify or manipulate the expression of a gene product, or to alter the biologic properties of living cells, to treat or cure a disease. It may replace a disease-causing gene, inactivate a disease-causing gene, or introduce a new or modified gene.[4]
- Costs of gene therapies, when combined with hospital and drug costs, are very expensive, ranging from $100,000 to $3 million per treatment (***see Factsheet: Expensive Drugs for Rare Diseases***) and may require

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[1] Internal Precision Medicine and Genetic Services tracking

[2] MIT. (2017). *Financing of Cures in the US*. Retrieved March 14, 2018, from https://tinyurl.com/y4yd2pyb

[3] Source: BC Cancer, Provincial Programs

[4] CADTH. (2018). *Gene Therapy: An Overview of Approved and Pipeline Technologies*, from https://cadth.ca/sites/default/files/pdf/eh0068_gene_therapy.pdf

specialized manufacturing facilities, patient care centres (specially accredited hospitals), clinicians, and technicians appropriately trained to effectively administer these medicines and ensure quality of care.[5]

- CAR-T therapies have shown clinical success; however, side-effects and prolonged hospital stays from treatment result in an estimated cost between $500,000 and $1.5 million per patient.[6]
- In addition, data for clinical effectiveness currently exists for only three years; the long-term, health-economic benefits for patients and health payers for these therapies are not fully known.
- KYMRIAH
    - The estimated list price of KYMRIAH is $450,000 for a one-time drug therapy treatment (not including hospital and other lifetime costs).
    - Canadian Agency for Drugs and Technologies in Health (CADTH) completed an extensive assessment of KYMRIAH. The health-economic report recommended a discount of 10% for pediatric patients and 65% for adult patients to meet health-economic thresholds of $50,000/quality-adjusted life-years.
- YESCARTA
    - The estimated list price of YESCARTA therapy is similar to KYMRIAH. CADTH similarly reviewed YESCARTA and recommended an 80% discount.
    - Negotiations with Gilead were led by the pan-Canadian Pharmaceutical Alliance have now concluded, but resulted in a substantially higher price than for KYMRIAH.

## FINANCIAL IMPLICATIONS

The average cost of OOC CAR-T for a BC patient was 1.2 million between 2019 to 2020 and ranged from $0.990 millionto $1.7 million CDN.[7]

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**Approved by:**

June 8, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 10, 2021 - Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
June 10, 2021 – Brenda Rafter, A/ED obo Philip Twyford, ADM, Finance and Corporate Services Division

[5] CADTH (2018). Retrieved February 2018, from: https://www.cadth.ca/sites/default/files/pdf/feedback/DRAFT_EH0068.pdf
[6] CADTH and CAPCA CAR T-Cell Therapy Meeting – Preliminary Summary Report and Action Plan (February 28, 2018)
[7] Health Sector Workforce and Beneficiary Services Division, MSP OOC Program, May 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Generic Drug Prices

### TOPIC

- PharmaCare covers generic drugs as part of BC's Low-Cost Alternative Program.
- Currently, the major factors influencing the price of generic drugs are: the Drug Price Regulation (as defined in the *Pharmaceutical Services Act*), market competition and supply, and the jointly developed pan-Canadian Pharmaceutical Alliance (pCPA) Generics Initiative, including the Tiered Pricing Framework (TPF), which is intended to improve drug pricing.

### CURRENT SITUATION

- This is the third year of the 5-year Generics Initiative that ends on March 31, 2023.
- Generic drug pricing is assessed through pCPA Centralized Price Confirmation process using the TPF.
- BC is actively involved in collaborating with pCPA and participating jurisdictions to leverage the strength of a national approach, create greater consistency across jurisdictions and bring Canada more in line with international pricing.

### KEY FACTS

- In November 2012, BC passed the *Pharmaceutical Services Act* which defined the Drug Price Regulation (Regulation).[1]
- On April 1, 2014, the pCPA and Canadian Generic Pharmaceutical Association (CGPA) agreed to a 3-year TPF for new generic drugs and price reduction of 18 molecules over the 3 years.
    - Under the 3-year TPF, prices of new generic drugs supplied by only 1 manufacturer (single-source) would be priced at 75% of the brand drug price (85% if a Product Listing Agreement for the brand name product does not exist). A second entry in the market (resulting in 2 manufacturers) would drop prices to 50% of the brand drug price. Entry of a third manufacturer would trigger a drop to 25% of the brand drug price for oral solids (or 35% for all other drugs).
    - During the 3 years, the 18 commonly used generic drugs were set at 18% of the brand name price[2].
- In September 2016, the pCPA and the CGPA agreed to a bridging arrangement to extend the TPF for an additional year (to March 31, 2018) in exchange for further reduction in price of 6 of the 18 common generic drugs from 18% to 15% of brand.
- On April 1, 2017, the Regulation was amended. Key improvements to the Regulation included the elimination of the annual price confirmation process, accepting submissions for exclusive listings, and relaxing our delisting practice.
- On January 29, 2018, BC as a co-lead announced a new 5-year initiative that would reduce prices of nearly 70 of the most commonly prescribed drugs in Canada by 25% to 40% effective April 1, 2018, resulting in overall discounts of up to 90% off the price of their brand-name equivalents. Consequently, it is estimated that there will be nearly $3 billion of savings across the country, this is expected to save BC approximately $110 million over the span of the initiative.[3] The new pCPA initiative also continues the operation of the TPF.
- The TPF does not supersede any existing policies, regulations or commitments in BC. Specifically, the TPF will not prevent BC from accepting pricing below that defined through the TPF.
- Any issues related to implementation of the TPF are managed through the pCPA Office.
- Effective April 1, 2019, the following amendments of the Regulation were implemented to assist BC to better align with other jurisdictions and to be consistent with the TPF through the pCPA's new initiative:
    - modernizing MALP from 20% to 25% of brand drug price for oral solids;
    - elimination of the exclusive listing process;
    - adopting brand drug price from another jurisdiction for MALP calculation.
- The pCPA and jurisdictions will continue to engage stakeholders, including pharmacists and representatives of pharmacies and distributors, on opportunities to improve business models related to generic drugs.

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[1] Pharmaceutical Services Act: Drug Price Regulation http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/344_2012

[2] The pan-Canadian Pharmaceutical Alliance, Canada's Premiers: http://www.canadaspremiers.ca/en/initiatives/358-pan-canadian-pharmaceutical-alliance.

[3] Statement on Generics 2.0: Reduced generic drug pricing: https://news.gov.bc.ca/releases/2018HLTH0006-000112

## FINANCIAL IMPLICATIONS

- PharmaCare spent approximately $198 million on multi-source drugs in 2019/20[4].
- Multi-source drugs represented 80% of the total number of prescriptions subsidized by PharmaCare and 20% of PharmaCare's total drug expenditures in 2019/20.[5]
- The new 5-year pCPA initiative is expected to save BC approximately $110 million over the span of the initiative[6].

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**Approved:**
June 1, 2021 - Christine Voggenreiter, obo Martin Wright, Health Sector Information, Analysis and Reporting Division
May 31, 2021 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
February 12, 2021 – Peter Klotz A/CFO obo Philip Twyford ADM, Finance and Corporate Services Division

[4] HSIAR Analysis of PharmaNet Data, (September 22, 2020)
[5] HSIAR Analysis of PharmaNet Data, (September 22, 2020)
[6] Government of BC (2018). News Release: *Statement on Generics 2.0: Reduced generic drug pricing.* Retrieved from: https://archive.news.gov.bc.ca/releases/news_releases_2017-2021/2018HLTH0006-000112.pdf

# LEGISLATIVE SESSION - FACT SHEET

## Genetics, Genomics and Precision Medicine

### TOPIC

The Ministry of Health provides a range of genetics, genomics, and precision medicine services through its health authorities to support health and wellness of British Columbians. The Ministry is working towards a sustainable provincial regulatory, policy, and oversight framework to further enable publicly funded genetics, genomics, and precision medicines.

### CURRENT SITUATION

- Precision medicine (PM) is a form of medical practice that aims to tailor treatment to a patient-based on the underlying genetic causes of a patient's condition. Tools employed in PM can include diagnostic options such as genome sequencing as well as treatment options such as gene therapies.
- PM covers a vast spectrum of diseases and conditions. Delivery of PM within the health system is managed through laboratory services hospital services, as well as access to novel therapeutics such as cell and gene therapies.
- The Ministry's Precision Medicine and Genetic Services Unit works closely with all health authorities to provide high quality and equitable access to genetic services throughout the province.
- The Precision Medicine and Genetic Services team is engaged in a number of key policy areas to assess and when appropriate expand genetic, genomic, and PM services in BC. These include:
    - **Pharmacogenomics (PGx)** – the Ministry is building on the extensive work that has been performed with external partners since 2017, including developing a health-economic modeling tool with Deloitte, and supporting research in PGx through Genome BC and developing a PGx Policy Framework. See the *Pharmacogenomics – Current State in BC Factsheet* for further details.
    - **Gene therapies/CAR T-cell therapy** - the Ministry is working on initiatives to explore the implementation of novel gene therapies/CAR T-cell therapy in BC and across Canada, including collaboration with federal and provincial partners on potential pan-Canadian implementation strategies. BC recently took on the chair role for the FPT Car T-Cell Advisory Committee. See the *Gene Therapies/CAR T-cell Therapy Factsheet* for further details.
    - **Genetic Non-Discrimination Act** - The Ministry is part of a cross-ministry working group reviewing the use of, or requirement for, genetic testing information in insurance and extended health contracts, including the potential to introduce "genetic characteristics" as a prohibited ground of discrimination to the BC Human Rights Code. See the *Genetic Non-Discrimination Factsheet* for further details.
    - **Genetic testing/out-of-province and out-of-country laboratory and genetic testing -** On June 1, 2018, the out-of-province/out-of-country (OOP/OOC) laboratory and genetic testing program was transitioned from the Ministry to the BC's Agency for Pathology and Laboratory Medicine (BCAPLM), an agency of the Provincial Health Service Authority (PHSA), with the intent of strenghtening the clinical and evidence based review framework for OOP/OOC laboratory and genetic testing. The Ministry contines to work with the program to develop policy as required and has retained the program budget and data for health system planning purposes. See the *OOP/OOC Laboratory and Genetic Testing Program Oversight Factsheet* for further details.
    - **Precision medicine workforce planning -** The Ministry is collaborating with the PHSA on workforce planning, including the current and future role of genetic counsellors in BC.

### KEY FACTS

- In 2016, the Ministry initiated a strategic policy framework to address gaps and opportunities for PM in BC. Stakeholder feedback was used to prioritize policy work, create networks of expertise, and develop a sustainable service delivery model for providing PM services across the health sector.
- The PHSA, through global budget funding, foundation donations, and research grants, provides most complex genetic tests/services through the following entities:
    - Canada's Michael Smith Genome Sciences Centre,
    - BC Prenatal Genetic Screening Program,

  - BC Cancer Agency's (BCCA) Hereditary Cancer Program,
  - BCCA's genetic pathology laboratories,
  - Provincial Medical Genetics Program (at Women's and Children's Hospitals), and
  - Public Health and Microbiology Reference Laboratory (at BC Centre for Disease Control)
- PHSA also has performance contracts with the Vancouver Coastal and Fraser Health Authorities whose hospitals deliver genetic testing, therapy, and related services. Other health authorities have established additional genetic testing and sequencing services independent of PHSA oversight.

## FINANCIAL IMPLICATIONS

Public expenditures for genetic testing and precision medicine/therapy will continue to increase over time. Development of a transparent provincial policy framework will provide government with the tools for supporting the most appropriate, effective, and financially sustainable personalized medicine solutions for patients and families. Some PM solutions have the potential to generate health care savings in the long term (e.g. tests that decrease adverse drug reactions). However, test costs are higher than traditional lab tests and this is creating pressure on global health budgets leading some jurisdictions to increasingly adopt user-pay solutions. BC is closely monitoring lessons learned within Canada, the UK, USA, Australia, and other countries.

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**Approved:**
January 14, 2020 – Ian Rongve, ADM, Provincial, Hospital and Laboratory Health Services Division
January 17, 2020 – Eric Larson obo ADM Martin Wright, ADM, Health Sector Information Analysis and Reporting Division
October 7, 2020 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Hepatitis C Drug Coverage

### TOPIC

- Hepatitis C virus (HCV) is a preventable, communicable disease which exhibits variable disease course and disease outcomes.
- Based on 2012 data, of those infected patients, approximately 25% clear the infection spontaneously and the remainder develop chronic hepatitis C (CHC).[1]
- Based on 2018 data, an estimated 61,000 people in BC have been infected with HCV. Of these, an estimated 13% are undiagnosed and may be unaware they have HCV. For those who do not self-resolve their infection, many remain in stable sub-clinical disease for years or decades before the disease may advance.[2]
- CHC morbidity is usually related to disease symptoms or cirrhosis and death is usually caused by end-stage liver disease or hepatic cancer.
- There are six genotypes of HCV. Most (64%) HCV infections in Canadians are Genotype 1. Genotypes 2 (14%) and 3 (20%) are the next most common.[3]

### CURRENT SITUATION

- Direct-acting antiviral agents (DAAs) are the main treatment for CHC due to their efficacy and safety and their well-documented ability to achieve high cure rates, i.e. sustained virologic response (SVR).
- Since 2016, several new DAAs were approved by Health Canada and received positive recommendations from the Canadian Drug Expert Committee, part of the Common Drug Review, for the treatment for CHC.
- Because these drugs are clinically effective but very expensive, BC co-led with Ontario the pan-Canadian Pharmaceutical Alliance negotiations and reached agreements with the manufacturers to improve accessibility to CHC treatments and ensure financial affordability and sustainability.
- To access coverage for DAA treatments, a prescriber must submit a request to PharmaCare's Special Authority, providing lab and diagnostic information that outlines how their patient meets the coverage criteria.
- Effective October 30, 2019, PharmaCare accepts Special Authority requests for DAA treatments submitted by nurse practitioners sufficiently experienced in treating CHC.
- The BC Centre for Disease Control continues population-level monitoring of HCV infected people in BC across cascades of care.
- The Ministry has been monitoring expenditure of DAAs and is coordinating an evaluation plan to monitor other program outcomes.

### KEY FACTS

- PharmaCare coverage for adult patients with CHC is based on treatment history (treatment-naïve or experienced, i.e. with or without prior exposure to other CHC treatments), genotype (genotype 1, 2, 3, 4, 5, or 6, or mixed genotype), liver fibrosis stage (F0 or greater, Metavir scale or equivalent) including decompensated cirrhosis.
- PharmaCare covers treatment-naïve or treatment-experienced adults with CHC genotype 1, 2, 3, 4, 5, 6, or mixed genotype with the following drug regimens:
    - Pan-genotypic regimens (i.e., for genotype 1 to 6): sofosbuvir-velpatasvir (Epclusa™) and glecaprevir-pibrentasvir (Maviret™).
    - Genotypic-specific treatment regimens: ledipasvir-sofosbuvir (Harvoni®) for genotype 1 and elbasvir-grazoprevir (Zepatier™) for genotype 1 or 4

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[1] Source: Sofia R. Bartlett Amanda Yu Nuria Chapinal Carmine Rossi Zahid Butt Stanley Wong Maryam Darvishian Mark Gilbert Jason Wong Mawuena Binka Maria Alvarez Mark Tyndall Mel Krajden Naveed Z. Janjua, *The population level care cascade for hepatitis C in British Columbia, Canada as of 2018: Impact of direct acting antivirals* First published: 24 August 2019 https://doi.org/10.1111/liv.14227

[2] Source: Sofia R. Bartlett Amanda Yu Nuria Chapinal Carmine Rossi Zahid Butt Stanley Wong Maryam Darvishian Mark Gilbert Jason Wong Mawuena Binka Maria Alvarez Mark Tyndall Mel Krajden Naveed Z. Janjua, *The population level care cascade for hepatitis C in British Columbia, Canada as of 2018: Impact of direct acting antivirals* First published: 24 August 2019 https://doi.org/10.1111/liv.14227

[3] Source: Robert P Myers, Mel Krajden, Marc Bilodeau et. al, Burden of Disease and Cost of Chronic Hepatitis C virus infection in Canada. Can J Gastroenterol Hepatol 2014 May; 28(5): 243-250.

- PharmaCare also covers salvage regimens for patients who have tried and failed treatment with a DAA (i.e., DAA treatment-experienced). PharmaCare covers DAA treatment-experienced adults with CHC genotype 1, 2, 3, 4, 5 or 6 with the following drug regimens:
  - Pan-genotypic regimen: sofosbuvir-velpatasvir-voxilaprevir (Vosevi™).
  - Genotypic-specific regimen: glecaprevir-pibrentasvir (Maviret™) for genotype 1.
- On June 11, 2020, PharmaCare modified the treatment duration for coverage for glecaprevir-pibrentasvir (Maviret) from 12 weeks to 8 weeks for treatment-naïve patients with compensated cirrhosis and CHC genotype 1, 2, 4, 5, or 6 (not genotype 3 infection). Due to new clinical evidence, 8 weeks has been found as effective and safe as 12 weeks treatment.
- PharmaCare is also reviewing the treatment duration for coverage for glecaprevir-pibrentasvir (Maviret) from 12 weeks to 8 weeks for treatment-naïve patients with compensated cirrhosis and CHC genotype 3.

**FINANCIAL IMPLICATIONS**

- Although the cost per course of treatment for the DAAs is very high, they are considered cost-effective from a pharmacoeconomic perspective because they demonstrate high curative rates of CHC, thus offsetting downstream health system costs.
- In 2019/20, PharmaCare paid $142.44 million for CHC medications.[4] During the same time, 2,942 patients received PharmaCare coverage for CHC medications.[5]

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**Approved:**
January 21, 2021 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
January 27, 2021 – C. Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 11, 2021– Peter Klotz A/CFO obo Philip Twyford ADM, Finance and Corporate Services Division

[4]Source: PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, June 25, 2020
[5] Source: PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting Division, June 25, 2020

# LEGISLATIVE SESSION - FACT SHEET

## Insulin Pumps

### TOPIC

- An overview of PharmaCare's insulin pump coverage policy.
- Diabetes coverage policies must be evidence-based, informed by health care experts and stakeholders, and support improved patient health outcomes. They must also be fair and equitable, ensure value for money and support cost containment strategies to ensure program sustainability.

### CURRENT SITUATION

- PharmaCare covers insulin pumps and supplies for people who have Type 1 or other forms of diabetes requiring the use of insulin. An insulin pump requires pre-approval under Special Authority (SA) to be eligible for coverage.
- Three insulin pumps are currently covered by PharmaCare: under Tier 1, pumps made by Insulet Canada and Ypsomed AG; and under Tier 2 a pump made by Medtronic Diabetes Canada.
- PharmaCare has recently undergone a review of Continuous Glucose Monitoring (CGM) and Flash Glucose Monitoring (FGM) devices and entered into a competitive value process (CVP) with the manufacturers of the continuous and flash glucose monitors. A listing decision to provide PharmaCare coverage for the Dexcom G6 continuous glucose monitor (CGM) is expected in June 2021. (See also Fact Sheet "Continuous and Flash Glucose Monitors").
- The Dexcom G6 does not directly interface with any of the approved insulin pumps that PharmaCare covers, to create a closed-loop hybrid pump system. The Dexcom G6 was reviewed and chosen based on its blood glucose monitoring functionality alone.

### KEY FACTS

- Diabetes is a serious health problem that is growing worldwide. At the start of 2019, Diabetes Canada estimated that 520,000[1] people, or 10%[1] of the population in BC, had diabetes.
- On July 3, 2018, PharmaCare extended insulin pump coverage to British Columbians of all ages.
- To access this coverage, the patient's endocrinologist or physician specializing in diabetes must request pre-approval.
- Eligible patients are granted SA coverage for a Tier 1 device, which is currently available at no cost to the recipient, regardless of their PharmaCare plan or deductible. Patients with exceptional clinical conditions that require treatment with a Tier 2 device may be eligible for exceptional SA coverage. The cost of the Tier 2 device is subject to the patient's PharmaCare deductible and family maximum.
- Coverage is provided for 1 insulin pump every 5 years.
- Insulin pumps range in cost from $6,000 to $7,000 and last for approximately 5 years.
- PharmaCare also covers the rapid-acting insulins used in insulin pumps, up to a maximum allowable cost that aligns with the lower cost of regular insulin.

**Policy Development**

- On November 17, 2008, PharmaCare started covering 1 insulin pump every 5 years for patients under the age of 19.
- On November 17, 2008, PharmaCare also expanded coverage of insulin pump supplies for beneficiaries of all ages who used insulin pumps to manage their diabetes.
- On April 1, 2014, PharmaCare extended insulin pump coverage to include British Columbians aged 25 years and younger. Extending coverage to include these patients was intended to ensure young adults transitioning into adulthood could focus their attention and resources on education.
- In Spring 2018, PharmaCare invited manufacturers to participate in a competitive value process (CVP) and propose confidential pricing for insulin pumps and supplies. Only 2 brands of pumps were available in BC at

[1] Data Source: Diabetes Canada, Diabetes in British Columbia (https://www.diabetes.ca/DiabetesCanadaWebsite/media/About-Diabetes/Diabetes%20Charter/2019-Backgrounder-British-Columbia.pdf).

the time, made by Insulet Canada and Medtronic Diabetes Canada. The CVP resulted in a tiered coverage model for patients of all ages and bound PharmaCare to a 5 year contract with each manufacturer.

- On July 28, 2020, Ypsomed AG's YpsoPump starter kit was added as an eligible benefit under the Tier 1 insulin pump category; the starter kit includes an insulin pump and three months of supplies.

## FINANCIAL IMPLICATIONS

- The annual cost to the BC Government through the PharmaCare program for diabetes medication and supply coverage increased by $4.20 million or 6% from 2018/19 to 2019/20 ($76.03 million and $80.23 million respectively).[2]
- In 2019/20, PharmaCare expenditure for insulin pumps was $2.67 million[2], and for insulin pump supplies was $6.58 million.

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**Approved:**

June 3, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory, and Blood Services Division
June 7, 2021– C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
June 8, 2021 - Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division

[2] PharmaNet data, Health Sector Information, Analysis and Reporting June 26, 2020.

# LEGISLATIVE SESSION- FACT SHEET

## LifeLabs Security Breach

### TOPIC

- In late October 2019, LifeLabs detected a cyber-attack involving the company's information systems.
- Approximately 15 million Canadian customers' personal information was affected, predominately in Ontario and British Columbia.
- The June 2020 release of the joint report from the Office of the Information and Privacy Commissioner of BC (OIPC) and Office of the Information and Privacy Commissioner of Ontario (IPC) was delayed due to LifeLabs requesting a judicial review.
- On June 25, 2020, the OIPC and IPC publicly released a summary of their findings, including 5 orders that LifeLabs would be required to address regarding security and privacy. LifeLabs is now compliant with these orders.

### CURRENT SITUATION

- A copy of the joint OIPC and IPC report has not yet been fully released nor received by government, as LifeLabs took the position that some of the information contained in the report is privileged or confidential.
- LifeLabs has requested a review of the assertion of privilege by the courts in both BC and Ontario; however, court dates have yet to be determined for the review.
- The joint OIPC and IPC report issued (and publicly released) 5 compliance orders for LifeLabs related to security monitoring, PHIPA (Ontario) and PIPA standards, data collection, breach notifications, and Ontario data contracts.
- Three of the 5 Orders relating to security, data, and breach notifications were completed before their compliance deadline of August 7, 2020; whereas, Order 2 regarding PHIPA/PIPA compliance was completed by its September 30, 2020 deadline, and Order 5 regarding data contracts in Ontario was completed by its February 7, 2021 deadline.
- LifeLabs has enhanced its security program by appointing a new Chief Security Officer and Chief Information Officer, establishing an Information Security Council, holding cybersecurity awareness events for staff, and making financial investments in its effort to achieve ISO 27001 certification for information security.
- LifeLabs has also developed a comprehensive IT security roadmap to address all the information security requirements outlined in the Privacy and Security schedules in the Master Laboratory Services Agreement (MLSA). As of their quarterly Privacy and Security Update for March 2021, LifeLabs completed/implemented 59% (45 of the 76) of the requirements and plans to complete all planned activities by the end of 2023.

### KEY FACTS

- On October 28, 2019, LifeLabs informed the Ministry of a potential data security breach caused by malicious software operating in LifeLabs' booking systems.
- The cyber-attack involved unauthorized access by an unidentified criminal attacker to LifeLabs' computer systems containing customer personal information.
- LifeLabs hired world-class cyber security experts to isolate and secure the affected systems, determine the scope of the attack, and to identify and remediate any vulnerabilities within its systems. LifeLabs also engaged with law enforcement.
- On November 7, 2019, LifeLabs advised the OIPC that BC residents' personal information was breached.
- Through a third-party cyber security expert, LifeLabs paid an undisclosed amount of ransom to obtain the information taken through the cyber-attack.
- The LifeLabs customer information impacted by the cyber attack included names, addresses, emails, logins, passwords, dates of birth, health card numbers, gender, phone numbers, password security questions and answers, and laboratory test results.
- LifeLabs delayed issuing the notification following the discovery of the cyber-attack to ensure its systems were adequately protected to prevent against subsequent attacks that might occur once the public notification had been issued. LifeLabs also required additional time to ensure all resources were in place to conduct such a wide scale notification.

- LifeLabs worked closely with the Ministries of Health and Citizens' Services (CITZ), as well as information security personnel at the Provincial Health Services Authority (PHSA), and consulted with the OIPC, to develop a plan to notify affected BC residents of the incident and to offer 1 year of cyber security protection services to customers through TransUnion that included credit monitoring, credit reporting, dark-web monitoring and identity-theft insurance.
- On December 17, 2019, the OIPC and IPC issued a joint news release on the LifeLabs Privacy Breach OIPC/IPC investigation, and directed concerned individuals to contact LifeLabs' call centre with any questions they had about the incident.
- On December 17, 2019, LifeLabs issued a public notification through its website and via press release. LifeLabs directly notified individuals whose test results were affected through a mailed or emailed letter. If no test results were involved for an individual, LifeLabs indirectly notified these customers through public announcements (e.g. local newspapers), the call centre and a dedicated website.
- According to LifeLabs, the databases and systems that were affected were not connected to provincial publicly-funded health information systems; thus, the BC Government or health authorities' databases and systems were not affected by the cyber-attack.
- In June 2020, the Saskatchewan Information and Privacy Commissioner issued a report about the breach, critiquing LifeLabs and the Saskatchewan Health Authority for not providing enough information to impacted customers, a lack of written security policies and safeguards, and the inadequacy of their respective investigation reports.
- In BC the response to the breach was comparatively swift and coordinated with the rapid deployment of a cross-ministry Incident Response team, with representation from the Ministry, CITZ, and PHSA, that met daily to coordinate the response.
- Effective April 1, 2020, the new LifeLabs MLSA includes enhanced privacy and security provisions to ensure adequate controls over personal information, and LifeLabs is subject to the *Freedom of Information and Protection of Privacy Act*.
- The PHSA and the Ministry retain full control of records and protected information, enhancing the public's right of access to records.
- LifeLabs also submitted a Data Management Plan, detailing policies, procedures, and data security measures, before the MLSA was signed. The document was reviewed and signed off by PHSA security and privacy leadership.
- PHSA and LifeLabs signed a letter confirming LifeLabs' commitment to addressing the OIPC's BC recommendations to ensure the future security of personal information.

## FINANCIAL IMPLICATIONS

- In 2019/20, the Ministry paid LifeLabs Government under the third year of a Laboratory Services Agreement between the Ministry and LifeLabs.[1]
- Effective April 1, 2020, the MLSA with LifeLabs committed approximately Government over 2 years:
  - 2020/21: Government
  - 2021/22: Financial Information

**Approved:**
June 3, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 9, 2021 – Brenda Rafter obo Philip Twyford ADM, Finance and Corporate Services Division

[1] Per Health Sector Information, Analysis and Reporting Division
[2] Master Laboratory Services Agreement, Schedule C, S.2.1, Initial Fixed Period Annual Payment.

# LEGISLATIVE SESSION - FACT SHEET

## Master Laboratory Service Agreement with LifeLabs

### TOPIC

Effective April 1, 2020, a Master Laboratory Services Agreement was signed by the Ministry of Health, the Provincial Health Services Authority (PHSA), and LifeLabs BC LP (LifeLabs), for the provision of community-based laboratory services in BC. The Agreement has an innovative shared risk economic model for fixed annual payments and enhances a sustainable public-private service delivery model.

### CURRENT SITUATION

- LifeLabs is the largest community-based private lab provider in BC and is the result of the amalgamation of multiple private lab companies over the last 20 years.
- The company operates 7 laboratories and 129 Patient Service Centres (i.e. specimen collection sites) across the province, the majority of which are concentrated in the Lower Mainland.[1]
- LifeLabs performs approximately 66% of the provincial laboratory outpatient tests under the Agreement with the Province, accounting for 94% of the payments to private providers in 2020/21.[2]
- In 2020/21, LifeLabs completed over 32 million tests[3] for 4.7 million patient visits.[4]
- The current two-year Advice/Recommentations; Government Financial Information Advice/Recommentations; Government Financial Information This new model offers more certainty regarding annual expenditures and continuity of patient care.
- As of April 2018, the management of day-to-day contract activities associated with the Agreement is performed by the PHSA's Alliance Management Office, with support and oversight from the Ministry.
- As part of the Province's response to the COVID-19 pandemic, LifeLabs is providing critical logistical / transportation support for the movement of COVID-19 specimens in the lower mainland, and is the lead on building of bidirectional interfaces that will allow disparate public laboratory information systems to share COVID-19 data. Advice/Recommentations; Government Financial Information
- LifeLabs performed on average 500-600 publicly funded COVID-19 (NAT) tests per day between March 2020 and March 2021 to help the Province maintain an appropriate testing capacity. As of April 2021, the Regional Health Authorities have reached sufficient COVID-19 (NAT) testing capacity, so the LifeLabs' COVID-19 testing capacity is no longer needed.
- The current Agreement expires on March 31, 2022. The Ministry may elect to extend it for Advice/Recommentation by giving LifeLabs written notice three months prior to the end of the Agreement (December 31, 2021).

### KEY FACTS

- The *Laboratory Services Act* (LSA) created the authority for the Minister to enter into agreements with laboratory service providers, affording government better oversight of provincial laboratory services and community providers for contractual obligations related to quality, security, privacy, and scope of services.
- The first Laboratory Services Agreement with LifeLabs, from April 1, 2017, to March 31, 2020, was based on a fee-for-service payment model that used volumes and cost per test along with a proportional allocation and risk-mitigating formula to calculate annual payments.
- In January 2019, the Minister approved a mandate to negotiate a new agreement with LifeLabs, with the objectives of establishing a new financial model Advice/Recommentations; Government Financial Information Advice/Recommentations; Government Financial Information
- In March 2020, the Ministry, PHSA, and LifeLabs concluded negotiations that allowed the parties to enter into the new Agreement, which was signed April 1, 2020.

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[1] Schedule J of the Master Laboratory Services Agreement lists all LifeLabs Facilities as well as Health Areas and Long Term Care Facilities serviced by LifeLabs' Mobile Collection Services, and Public Facilities serviced by LifeLabs' Logistics and Transportation service.

[2] Medical Services Plan database, paid to May 31, 2021. Extracted June 7, 2021. Note: A portion of the underlying data is considered an estimate and pending reconciliation as it falls under the terms of various agreements.

[3] Ibid.

[4] Ibid., 6.

- As a Party to the Agreement, PHSA has significant rights and responsibilities regarding day-to-day contract administration and monitoring through the Alliance Management Office.
- Key Agreement terms and benefits include:
  - Details of the key terms of the Agreement are outlined in 14 schedules (e.g., Services, Pricing and Payment Model, Reporting and Key Performance Indicators, and Privacy and Data Security Protection).
  - LifeLabs is subject to the requirements of the *Freedom of Information and Protection of Privacy Act* in its performance of services under the Agreement. The Province/PHSA have ownership and control of the personal information under the Agreement.
  - Governance structure includes a Joint Strategic and Operations Oversight Committee comprised of senior executives from PHSA, the Ministry, and LifeLabs. The Committee is tasked with Agreement oversight, managing issues, monitoring performance, and determining continuous improvement opportunities and innovation projects.
  - Cabinet Confidences; Government Financial Information
  - Annual payments are predictable with 24 equal payments based on volumes and target efficiencies calculated from the previous cycle.
  - LifeLabs is contractually obligated to provide its current scope of services for the duration of the Agreement, and any Advice/Recommentations; Government Financial Information defined governance structure.
  - The Agreement Advice/Recommentations; Government Financial Information Advice/Recommentations; Government Financial Information

## FINANCIAL IMPLICATIONS

- From April 1, 2017, to March 31, 2020, the first Agreement committed approximately Government over 3 years:
  - 2017/18 expenses were : Government Financial
  - 2018/19 expenses were : Information
  - 2019/20 expenses were :
- Effective April 1, 2020, the new Agreement committed approximately Government over 2 years:
  - 2020/21: Government
  - 2021/22: Financial Information

**Approved:**
June 4, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 10, 2021- Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division
June 10, 2021– Eric Larson obo Martin Wright, ADM Health Sector Information, Analysis and Reporting Division

[5] Summary of Year 2 (2018/19) Reconciliation for the Laboratory Services Agreement with LifeLabs. (Attachment to CLIFF 1148632, letter sent to LifeLabs, on February 20, 2020).
[6] Per Information Briefing Note: Laboratory Services Agreement Year 3 (2019/20) Reconciliation (CLIFF 1177225)
[7] Master Laboratory Services Agreement, Schedule C, S.2.1, Initial Fixed Period Annual Payment.

# LEGISLATIVE SESSION - FACT SHEET

# Methadone Maintenance Payment Program

## TOPIC

Payments and services provided by PharmaCare's Methadone Maintenance Payment Program.

## CURRENT SITUATION

- Pharmacies dispensing methadone for maintenance are reimbursed by PharmaCare for the drug cost up to the PharmaCare maximum price and a $10 dispensing fee, with a $7.70 interaction fee through PharmaCare's Methadone Maintenance Payment Program (MMPP) when ingestion of the drug is witnessed by a pharmacist.
- Due to COVID-19 circumstances, and Health Canada's temporary exemptions to the *Controlled Drugs and Substances Act* on March 19, 2020, the College of Pharmacists of BC (CPBC) made temporary policy amendments which permit pharmacists to authorize non-pharmacists to deliver and witness ingestion of OAT, remove patient signature requirements on accountability logs, and permit the transfer of prescriptions for controlled substances.
- The Ministry will continue paying the MMPP claims and fees related to the CPBC's COVID-19 related amendments and guidance, through Ministerial Orders.
- In 2019/20, 991 BC pharmacies dispensed methadone, with 19,422 clients participating in the Methadone Maintenance Program, at a total cost of $49.76M.
- In 2019, Metadol-D® (an unflavoured product), as well as a generic flavoured alternative to Methadose®, were added to the PharmaCare formulary as regular benefits, to provide more options for methadone patients.
- In exceptional circumstances, PharmaCare will cover compounded methadone.

## KEY FACTS

- Methadone is a long-acting, orally administered synthetic opioid used in opioid agonist treatment (OAT).[1]
- Community pharmacies dispense methadone throughout the province; the largest concentration is in the Lower Mainland.
- Pharmacies must enroll as an OAT provider with PharmaCare in order to receive the interaction fee.
- The MMPP does not include buprenorphine/naloxone (Suboxone), which was approved in October 2015 as a regular coverage benefit by PharmaCare, or Kadian® slow-release oral morphine, an alterative treatment for opioid use disorder approved as of June 2017. This means that PharmaCare does not pay an interaction fee when these drugs are dispensed.
- The current method of reimbursement was introduced by PharmaCare in 2001 to increase the number of pharmacies dispensing methadone to improve access to methadone therapy as a harm reduction measure. This goal has been realized: in 2019/20, 991 BC pharmacies dispensed methadone, up from 977 in 2018/19.[2]
- The *Pharmaceutical Services Act* prohibits pharmacies from offering cash or incentives of any kind to clients, including methadone patients. Pharmacy billing and compliance respecting methadone dispensing are investigated by PharmaCare Audit and the CPBC.
- In 2015, the the Ministry of Health reviewed the MMPP to identify issues with the program, such as improper billing of methadone claims and offering inducements, and prepared a report about PharmaCare's methadone related policies and, more broadly, methadone maintenance treatment in BC. Consultations regarding the report's findings were held with representatives from regulatory colleges, methadone providers, patients and patient advocacy groups, and public bodies.
- As a result, policy options were identified to better support patient-centered access to OAT in an appropriate healthcare setting. These options included low-barrier coverage, enhancements of the treatment environment and experience, and a revised professional fee structure.
- Low-barrier coverage for methadone and buprenorphine/naloxone (Suboxone) was announced on January 18, 2017, through the addition of these two drugs to the formulary of PharmaCare's Psychiatric Medications Drug Plan (Plan G).

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[1] For more information see 'Opioid Misuse' or 'Methadone (Methadose), Naloxone-Buprenorphine (Suboxone), Naloxone Fact Sheets.

[2] PharmaNet data, Health Sector Information, Analysis and Reporting 27 February 2019. Includes methadone maintenance PINs, PharmaCare accepted claims. Does not include Suboxone.

- The CPBC is responsible for ensuring (through mandatory training and practice audits, etc.) that pharmacists and pharmacy staff who provide services related to methadone maintenance know and apply the principles and guidelines established in the CPBC professional practice policies and Methadone Maintenance Treatment Policy Guide. The Guide was revised in 2014 to reflect the dispensing of Methadose® and to address issues such as the delivery of methadone to clients.
- The CPBC released a revised professional practice policy for methadone and other OAT drugs on January 1, 2018.
- The College of Physicians and Surgeons of BC (CPSBC) administered the Methadone Maintenance Program in BC until elements of the program were transitioned to the BC Centre on Substance Use (BCCSU), effective June 5, 2017. The BCCSU is responsible for the educational and clinical care guidance activities for all health care professionals who are prescribing medications to treat opioid use disorder, including the publication of clinical guidelines.
- With funding from Health Canada, the Ministry has contracted the BC Pharmacy Association to develop and deliver an OAT training program to all pharmacists dispensing OAT drugs. The program launched in November 2018 and workshops began in January 2019.
- The in-person workshops were paused in March 2020 due to the COVID-19 pandemic, and workshops were relaunched in November 2020 via virtual delivery.
- The Provider Regulation under the *Pharmaceutical Services Act* has been updated to support participation in the new OAT training program. The methadone maintenance provider sub-class has been replaced by the OAT provider sub-class. Participation in the MMPP is now contingent on continuing enrolment in the OAT provider sub-class, which depends on pharmacies meeting the new training requirements for OAT. Re-enrolment in the OAT provider sub-class is not required for previous enrollees.
- The drugs prescribed for OAT are subject to the Prescription Review Program administered by the CPSBC, whereby select drugs may be prescribed only in writing using a duplicate prescription pad.
- The Methadone Maintenance Program increased from 19,085 clients in 2018/19 to 19,422 clients in 2019/20.[3] The number of physicians actively prescribing methadone for maintenance increased from 714 to 832 between 2018/19 and 2019/20.[4]

## FINANCIAL IMPLICATIONS

PharmaCare's MMPP-related expenditures were approximately $49.76M in 2019/20.[5] Between 2014/15 and 2019/20, total related expenditures have grown at an annual rate of 3.0% while the number of patients receiving methadone for maintenance has grown at an annual rate of 3.6%.[6]

| MMPP related expenditures ($million) | | | | |
|---|---|---|---|---|
| **Fiscal year** | **Dispensing fee** | **Ingredient cost** | **Interaction fee** | **Total** |
| 2014/15 | $20.41 | $4.54 | $18.04 | $42.99 |
| 2015/16 | $21.01 | $4.68 | $18.90 | $44.59 |
| 2016/17 | $21.66 | $4.88 | $19.41 | $45.95 |
| 2017/18 | $24.40 | $5.78 | $20.41 | $50.59 |
| 2018/19 | $24.24 | $6.20 | $19.86 | $50.30 |
| 2019/20 | $23.98 | $6.60 | $19.18 | $49.76 |

Source: PharmaNet/HealthIdeas data

**Approved:**

January 27, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 1, 2021 - C. Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 12, 2021- Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[3] PharmaNet data, Health Sector Information, Analysis and Reporting, September 1, 2020. Includes methadone maintenance PINs, PharmaCare accepted claims. Does not include naloxone/buprenorphine (Suboxone and generics).
[4] PharmaNet data, Health Sector Information, Analysis and Reporting, September 1, 2020. PharmaCare accepted claims. Does not include naloxone/buprenorphine (Suboxone and generics).
[5] PharmaNet data, Health Sector Information, Analysis and Reporting, September 1, 2020. Includes methadone maintenance PINs. Does not include naloxone/buprenorphine (Suboxone and generics).
[6] PharmaNet data, Health Sector Information, Analysis and Reporting, September 1, 2020. Includes methadone maintenance PINs, PharmaCare accepted claims. Does not include naloxone/buprenorphine (Suboxone and generics).

# LEGISLATIVE SESSION - FACT SHEET

## Mifegymiso Coverage

### TOPIC

Mifegymiso (also known as RU-486) is a combination of drugs – mifepristone and misoprostol – used as an alternative to surgical abortion to terminate early-stage pregnancies.

### CURRENT SITUATION

- On January 15, 2018, PharmaCare began covering the full cost of mifepristone and misoprostol (Mifegymiso) for all BC residents.
- As of August 27, 2019, this coverage is through the 100%-paid PharmaCare Plan Z. Removing the cost barrier helps ensure any individual can access this option for terminating pregnancy.
- Surgical abortions in BC have experienced a downward trend since 100% paid coverage of Mifegymiso was introduced in 2018. There were nearly 26% fewer surgical abortions at less than 14 weeks performed in October 2020 as compared to October 2019, and 29% fewer than in October 2018.[1]

### KEY FACTS

- Mifegymiso is considered the gold standard for medical (non-surgical) abortion, and has been used safely and effectively in many countries since the late 1980s: France (since 1988); United Kingdom (1991); Sweden (1992); Austria, Belgium, Denmark, Finland, Germany, Greece, Luxembourg, the Netherlands, Spain, Switzerland (1999); and the United States (2000)[2], among other jurisdictions.
- On July 29, 2015, Health Canada announced market approval for Mifegymiso for use in medical abortions up to a gestational age of 49 days[3]. In April 2017, the federal Common Drug Review recommended Mifegymiso for public coverage.
- Changes in Health Canada's product monograph in November 2017 allowed pharmacists to dispense Mifegymiso directly to patients for use either at home or at a health facility. Pharmacists are not required to complete an education program before dispensing Mifegymiso; however, it is expected they have the appropriate knowledge to do so. Patients do not have to sign a consent form and the gestational age limit is 63 days.[4]
- The availability of Mifegymiso in BC supports a shift from surgical pregnancy termination in large urban centres (where 90% of abortions in BC had been provided)[5] to community/home-based pregnancy termination services. In Norway, the proportion of medical abortions increased with the introduction of Mifegymiso, from 6% of all abortions in 1998 to 82% in 2013, while the US saw an increase to more than 45% of pregnancies termination by medical abortion in 2014.[6,7]
- Increased access to Mifegymiso for medical abortion can increase provision of pregnancy termination in ambulatory, community and home settings. Mifegymiso utilization in rural and remote areas has increased since 2017.

<u>PharmaCare Coverage</u>

- Effective August 27, 2019, PharmaCare provides coverage of Mifegymiso under Plan Z ("Assurance" Plan), a new universal, no-cost drug plan. Eligibility for Plan Z requires beneficiaries to be residents of BC and enrolled in the Medical Services Plan.

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[1] MSP Data, Primary Care, Acute Care & Workforce Branch; Health Sector Information, Analysis and Reporting Division, February 17, 2021.
[2] Christin-Maitre, S., Bouchard, P., Spitz, I. M. (2000). "Medical termination of pregnancy". *New England Journal of Medicine* 342 (13): 946–56. https://www.researchgate.net/profile/Irving_Spitz/publication/12578321_Medical_Termination_of_Pregnancy/links/00b7d521fa60005c4a000000/Medical-Termination-of-Pregnancy.pdf
[3] Health Canada 2015. http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65030a-eng.php
[4] Health Canada 2017. http://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65030a-eng.php
[5] Norman, WV, Soon JA, Maughn N, Dressler J. (2013). "Barriers to rural induced abortion services in Canada: findings of the British Columbia Abortion Providers Survey (BCAPS)". *PLoS One* 8(6) doi: 10.1371/journal.pone.0067023.
[6] Jones RK and Jerman J, Abortion incidence and service availability in the United States, 2014, Perspectives on Sexual and Reproductive Health, 2017, 49(1):17–27, doi:10.1363/psrh.12015
[7] Løkeland M, Bjørge T, Iversen OE, Akerkar R, Bjørge L. Implementing medical abortion with mifepristone and misoprostol in Norway 1998-2013. International Journal of Epidemiology. 2017. 46(2):643-651 doi: 10.1093/ije/dyw270.

- Participating pharmacies must dispense Mifegymiso at no charge to any BC resident with a valid prescription. PharmaCare pays pharmacies a $10 dispensing fee for each kit they dispense. PharmaNet limits coverage to one Mifegymiso dispense, per patient, per day. If a patient loses the medication, the pharmacy is to provide the medication that day and to enter the claim the following day. Mifegymiso is restricted for medical abortion use only under Plan Z.
- The current out-of-pocket cost for Mifegymiso for individuals without PharmaCare coverage is approximately $324.
- From July 11, 2017 to January 14, 2018, PharmaCare covered Mifegymiso as a regular benefit, subject to the rules of a patient's PharmaCare plan. Patients covered under the Fair PharmaCare plan who did not reach their deductible or family maximum prior to filling their prescription would have been required to pay for all or part of the prescription costs.
- From January 15, 2018 to August 26, 2019, before Plan Z was launched, the Ministry of Health partnered with the BC Centre for Disease Control (BCCDC) to operate an interim coverage program to use their existing distribution system to supply pharmacies with the drug and facilitate 100% paid coverage of Mifegymiso.
- The number of Mifegymiso dispenses in the province by fiscal year is:[8]
    - 2016/2017: 91
    - 2017/2018: 1,844
    - 2018/2019: 4,922
    - 2019/2020: 6,327
    - 2020/2021: 8,205

## FINANCIAL IMPLICATIONS

- Between April 1 2020 and March 31 2021, PharmaCare paid $2.53 million in drug cost and dispensing fees for Mifegymiso under Plan Z[viii].
- For the interim coverage program with the BCCDC between January 2018 and August 2019, the approximate estimated cost for the drug product and distribution to pharmacies was $2.23 million[9]. Pharmacare also paid an estimated $75,000 to pharmacies in professional fees for dispensing Mifegymiso during this period.

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**Approved:**

February 25, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
April 6, 2021 - Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division
June 14, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

[8] PharmaNet Data, Community & Cross Sector Branch; Health Sector Information, Analytics and Reporting Division, June 14, 2021.
[9] Pharmaceutical Services Division, Ministry of Health

# LEGISLATIVE SESSION - FACT SHEET

## Naloxone Coverage

### TOPIC

Emergency-use naloxone is a potentially life-saving medication used to treat opioid overdose.

### CURRENT SITUATION

Since September 16, 2016, sale of emergency-use naloxone is no longer limited to pharmacies and may be sold anywhere in BC (to increase accessibility). It is also available free of charge through the BC Centre for Disease Control's (BCCDC) Take Home Naloxone program.

### KEY FACTS

- BCCDC operates the Take Home Naloxone (THN) program which provides free naloxone kits, training and education to patients at-risk of overdoses. Kits are available at harm-reduction sites, local health units, hospital emergency departments, corrections facilities, community pharmacies and First Nations sites.
- On September 21, 2016, the Ministry approved the CPBC's request to amend the BC Drug Schedules Regulation to deregulate and unschedule emergency use naloxone. This change allows naloxone to be sold over the counter and at locations outside pharmacies, which means health care sites, treatment centres and community agencies can carry and sell/distribute naloxone.
- On October 3, 2016, Health Canada approved the sale of Narcan® nasal spray.
- On December 20, 2017, the BCCDC expanded the Take Home Naloxone program to include distribution of free naloxone kits through participating community pharmacies.
- Intranasal naloxone is being distributed to RCMP detachments and some municipal police departments, as part of the work of the Joint Task Force. It is also available free of charge through an alternate service provider (Pacific Blue Cross), to clients supported through the First Nations Health Authority.
- Intranasal naloxone is not a PharmaCare benefit as the pan-Canadian Pharmaceutical Alliance negotiated with the manufacturer and the negotiated price was not sufficient to address incremental budget implications for BC.
- As of June 2020, the BCCDC has 1,732 active THN distribution sites and has distributed 202,531 naloxone kits throughout BC, of which 62,225 were reported as used to reverse an overdose.

### FINANCIAL IMPLICATIONS

- The naloxone spray (Narcan) is substantially more expensive ($145 list price per kit) than injectable naloxone (approximately $20-25 per kit procured by BCCDC).
- In 2019/20, the expenditure for THN was $11.06M.

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**Approved:**

January 29, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 9, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 12, 2021 – Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## National Pharmacare

### TOPIC

Canada is the only country with a universal health insurance program that does not provide universal coverage of prescription drugs. Instead, prescription drugs are covered by variable provincial and federal drug programs supplemented by private drug insurance. Recently the federal government has been raising national pharmacare as an issue for discussion.

### CURRENT SITUATION

- There are several potential approaches to implementing a national pharmacare program; however, there is a lack of national consensus on which approach is best and how to fund it.
- BC's primary healthcare priority is not national pharmacare but enhanced federal funding for healthcare through the Canada Health Transfer.
- At their December 2, 2019 meeting, Premiers called on the federal government to respect provincial/territorial (PT) jurisdiction over health care to ensure PT flexibility, and to use its fiscal capacity to increase the Canada Health Transfer by an annual escalator of 5.2%.

### KEY FACTS

- The 2020 BC Minister of Health mandate letter includes a commitment to: " [f]ight for a national pharmacare program while enhancing Fair Pharmacare by continually reviewing cost thresholds and drug eligibility with the goal of bringing the cost of prescription drugs down."
- BC PharmaCare already covers most of the drugs considered to be "essential". As a result, when considering implementation of an essential medicines program in 2017, BC opted instead to provide additional financial support for low income families via increased Fair PharmaCare assistance to achieve the same intent as the essential drugs proposal at a substantially lower cost.
- On February 28, 2018, the federal government announced the creation of the Advisory Council on the Implementation of National Pharmacare (the Advisory Council) to provide independent advice to the federal Ministers of Health and Finance on how to best implement a national pharmacare program. The final report[1] of the Advisory Council was released June 12, 2019.
- The Advisory Council, chaired by Dr. Eric Hoskins, former Ontario Minister of Health and Long-term Care, examined domestic and international models and consulted with provincial and territorial governments, Indigenous groups, health care industry groups and individual Canadians.
- The final report concluded that Canada's current patchwork of public and private drug plans is not meeting the needs of Canadians and is in need of reform. It recommended a universal, single-payer public prescription drug coverage program to ensure that all Canadians have equitable and affordable access to prescription drugs, similar to the vision of the *Canada Health Act*.
- The Advisory Council provided recommendations and a timeline for a national pharmacare program:
    - Create a Canadian Drug Agency (CDA) that would subsume some or all of the functions of the pan-Canadian Pharmaceutical Alliance, the Patent Medicine Price Review Board, the Canadian Agency for Drugs and Technologies in Health, and provincial drug review processes.
        - The CDA would develop a national formulary, beginning with an essential medicines list, to be in effect by January 1, 2022.
        - The CDA would then progressively expand the formulary to encompass a comprehensive list of cost-effective and evidence-based medications by January 1, 2027.
        - The CDA would develop a separate strategy and funding approach for expensive medicines for rare diseases, to be in place by January 1, 2022.
    - Create legislation similar to the *Canada Health Act* to require provinces to provide universal coverage of the national formulary, with a very small co-pay requirement.
    - Invest in drug data and information technology (IT) systems by providing time-limited transition funding for modernizing and improving interoperability of IT and records systems.

[1] Advisory Council on the Implementation of National Pharmacare, *A Prescription for Canada: Achieving Pharmacare for All*, 2019.

  - Provide federal funding to support the transition to a national pharmacare program, as well as to support the ongoing additional costs of the program, on an opt-in basis to provinces that meet the legislated requirements, similar to medicare under the *Canada Health Act*.
- BC has concerns about the design, impact, and potential cost of a national pharmacare program. Without a significant funding commitment from the federal government, the fiscal pressure for this initiative would be added to each province and territory.
- To guide the development of a national pharmacare program, BC proposed 4 key principles, which were adopted by all premiers at the July 2018 Council of the Federation meeting:
  1. Improving access through removing cost barriers for patients should be the focus;
  2. Development should be based on the best available evidence about potential benefits, risks, costs, and reliability of supply;
  3. Provinces and territories must retain responsibility for the design and delivery of public drug coverage; and
  4. Federal pharmacare funding must be long term, adequate, secure, flexible and take into consideration present and future cost pressures.
- On March 19, 2019, the federal government released its 2019 budget[2], which announced its intention to move forward on 3 foundational elements of national pharmacare: 1) the creation of a Canadian Drug Agency; 2) the Development of a national formulary; and 3) a national strategy for high-cost drugs for rare diseases.
- The federal Speech from the Throne on October 23, 2020, and the supplementary mandate letter to the federal Minister of Health on January 15, 2021, confirmed the federal government's ongoing commitment to these three elements.
- A federal private members bill (Bill C-213) has been proposed that would create a *Canada Pharmacare Act*, which establishes criteria and conditions in respect of drug insurance plans established under the law of a province that must be met before a cash contribution may be made.

## FINANCIAL IMPLICATIONS

- The National Pharmacare program outlined in the June 2019 report is expected to incur significant additional costs for BC, shifting costs from patients and third-party insurers to the public program.[3]
  - By 2022, the Advisory Council model anticipates net incremental spending of $542M for BC with implementation of coverage for the essential medicines list.
  - By 2027, with the full implementation of a comprehensive pharmacare formulary, BC's net incremental spending is anticipated to increase by $2.15B.
  - Nationwide, these costs are anticipated to be $4.11B additional by 2022 and $18.1B by 2027.
  - These estimates include generous cost-saving assumptions from confidential rebates on brand-name drugs to be negotiated with pharmaceutical companies.
- The report proposes these costs would be covered by a new federal transfer to be negotiated with the provinces, and the report does not specify or recommend any matching federal revenue sources.
- The 2019 federal budget[4] does not contain direct funds for a pharmacare program, only $35M over 2019/20 through 2022/23 to establish a CDA Transition Office, and $500M for each of 2022/23 and 2023/24 for a new high-cost drugs for rare diseases program.

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**Approved:**
October 9, 2019 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 1, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory & Blood Services Division
April 6, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

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[2] Government of Canada, *Investing in the Middle Class: BUDGET 2019*, 2019, p 57-62
[3] Advisory Council on the Implementation of National Pharmacare, *A Prescription for Canada: Achieving Pharmacare for All*, 2019, p 160-163.
[4] Government of Canada, *Investing in the Middle Class: BUDGET 2019*, 2019, p 57-62

# LEGISLATIVE SESSION - FACT SHEET

# Opioid Misuse

## TOPIC

Misuse of prescription opioids is associated with serious harms, including addiction, overdose, and possibly death, placing a significant burden on individuals and their families, health and social services systems, and public safety systems.

## CURRENT SITUATION

In 2020, an averge of 140 people died per month as a result of illcit drug toxicity each month.[1]

## KEY FACTS

- The Ministry of Health supports appropriate pain management but recognizes the risks associated with prescription opioid misuse.
- Programs and activities aimed at reducing the abuse and misuse of prescription opioids are provided through PharmaCare in collaboration with the Ministry of Health, the Ministry of Mental Health and Addictions (MMHA), the College of Physicians and Surgeons of BC (CPSBC), the College of Pharmacists of BC (CPBC), and the BC Centre on Substance Use (BCCSU).

PharmaCare Programs

Activities, and strategies aimed at decreasing opioid misuse include:

- The Restricted Claimant Program limits PharmaCare's medication coverage for certain "at risk" patients to a single prescriber and/or a single pharmacy to help increase patient safety and reduce medication misuse.
- Limiting the coverage of covered opioids to a maximum of 30 days per fill.
- Use of a trends report to regularly examine the use of covered opioids.
- Discontinuation of coverage for long-acting oxycodone (OxyContin®) in March 2012 and beginning of exceptional case-by-case coverage of a more abuse deterrent oxycodone product (OxyNeo®).
- Coverage of oral opioid agonist therapies (OAT) to assist with the treatment of opioid use disorder, including methadone, buprenorphine/naloxone (Suboxone®), hydromorphone tablets and injection, sustained-release oral morphine (Kadian®), and exceptional alternate opioid options.
- Manufacturer negotiation and regulatory support for access to Canadian development and supply of diacetylmorphine [heroin].

Data

- The PharmaNet allows health professionals to review a patient's medication history prior to prescribing or dispensing to watch for usage irregularities such as problematic medication use.
- A subset of PharmaNet data is used by the CPSBC's Prescription Review Program to ensure secure and appropriate prescribing of drugs like opioids. Where reviews demonstrate potentially problematic prescribing, individual physicians may be requested to participate in additional education for the prescribing of these types of medications.
- The Ministry has published the BC Controlled Prescription Drug Atlas which identifies opioid and benzodiazepine prescribing patterns around the province.

Naloxone Access

- In 2012, BC Centre for Disease Control and health authorities started creating and distributing Take Home Naloxone kits to individuals deemed to be high risk for opioid overdose.
- In April 2016, Health Canada and the CPBC changed the prescription only status of naloxone to allow it to be purchased at retail pharmacies anywhere without a prescription.
- In December 2017, the Take Home Naloxone Program expanded to community pharmacies.

[1] Source: BC Coroners Service. 2020. Illicty Drug Tocixity Deaths in BC January 1, 2010 – November 30, 2020. Posted December 21, 2020. Table 1, Pg 44. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug-update.pdf. Last Accessed February 4, 2021.

- In October 2016, Health Canada approved the sale of Narcan® Nasal, a nasal spray version naloxone. Police in some communities and guards in some jails and penitentiaries have been authorized to carry Narcan® Nasal.

Education and Guidelines

- In August 2013, the Provincial Academic Detailing Service launched a topic on "Opioids in Chronic Non-Cancer Pain: The Basics".
- In June 2016, the CPSBC released a new professional standard and guidance for the Safe Prescribing of Drugs with Potential for Misuse/Diversion, including opioids.
- In February 2017, the BCCSU released a provincial guideline for the clinical management of opioid use disorder. Both a shorter BC Guidelines version of the BCCSU guideline and a Provincial Academic Detailing topic on buprenorphine/naloxone (Suboxone®) were developed to help encourage more family physicians to prescribe this medication to patients diagnosed with opioid use disorder.
- In October 2017, the BCCSU released a provincial guideline for the use of injectable opioids agonists (e.g., hydromorphone) for the management of opioid use disorder. The Ministry, MMHA, and health authorities worked with BCCSU to implement the guideline.
- In November 2018, the BC Pharmacy Association released the Opioid Agonist Compliance and Management Program for Pharmacists Workshop online. The first live workshop was held in January 2019. This program was a collaborative project with significant input from the Ministry and others.

Colleges

- The Controlled Prescription Program, a partnership between the CPSBC, CPBC, College of Dental Surgeons of BC, BC College of Nursing Professionals, College of Midwives of BC, College of Veterinarians of BC, and the Ministry, reduces the potential for prescription forgeries by requiring prescriptions for designated prescription opioids and controlled drugs to be written on specially designed duplicate prescription pads.
- In July 2016, the CPSBC removed the requirement that physicians must hold an exemption to prescribe methadone prior to being able to prescribe Suboxone®, enabling any physician to prescribe it for opioid substitution therapy.
- In 2019, the Ministry contracted the CPSBC to develop a proposal for a fulsome BC Prescription Monitoring Program. This program will be aimed at helping to unsure safe prescribing and dispensing of medications in BC. The Summary Report was submitted to the Ministry on January 30, 2020. Review of the proposal has been delayed thus the date of implementation of the PMP is, as yet, uncertain.

Provincial Health Officer (PHO) Announcements

- On April 14, 2016, the PHO declared a public health emergency related to the significant increase in drug-related overdoses and deaths.
- On March 17, 2020, the PHO declared a public health emergency due to COVID-19, resulting in a dual public health emergency for both drug-related overdoses, and COVID-19.
- Subsequently, the BCCSU released guidelines for prescribing and dispensing during the dual public health emergency.
- On September 16, 2020, the PHO announced an expansion of access to pharmaceutical alternatives ("safer supply") for those with substance use disorder to decrease their reliance on the tainted street supply. Ministry staff are collaborating with the MMHA, BCCSU and other stakeholders to develop the prescribing and operational guidance for rapid roll out of this program.

## FINANCIAL IMPLICATIONS

N/A

**Approved:**

January 27, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 9, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

# LEGISLATIVE SESSION - FACT SHEET

# Out-of-Province/Out-of-Country Laboratory and Genetic Testing Program Oversight

## TOPIC

The majority of laboratory services required by BC patients are provided in BC laboratories; however, for specialized testing, specimens are sent to pre-approved out-of-province/out-of-country (OOP/OOC) laboratories. Most of these are for specialized genetic tests including exome sequencing, that constitute the majority of, and an increasing burden to, the OOP/OOC test budget.

## CURRENT SITUATION

- In June 2018, the OOP/OOC Laboratory and Genetic Testing Program was formally transfered to the Provincial Health Services Authority (PHSA) with the intent of strengthening the clinical and evidence-based review framework and ensuring appropriate clinical guidelines were developed and implemented. Today, medical geneticists work directly with physicians and hospitals to provide this important step in diagnosing patients.
- The program provides decisions on publicly funded tests as well as:
    - Client communications and administrative support
    - Clinical evaluation of requests and determination of test services available for patients, including use of expensive genetic sequencing
    - Enhanced OOP/OOC policy based on clinical expertise and previous Medical Services Commission coverage requirements
    - Financial reporting and forecasting to the Ministry of Health
- The Ministry continues to work with the program to develop policy as required and has retained the program budget and data for health system planning purposes.

## KEY FACTS

- Up until May 2018, access to laboratory and genetic testing through OOP/OOC providers was administrated directly by the Ministry. Over several years, an increase in need for complex genetic testing for patients with undiagnosed chronic diseases made it increasingly difficult for the Ministry to determine clinical need. A back log of patient assessments resulted in a 3-month wait time for families to learn whether their testing would be publicly funded or was needed at all.
- To date, the PHSA, utilizing specialized clinical geneticists and hospital resources, has improved the clinical assessment process and reduced the wait time to fund testing for patients from several months to approximately seven days. This is a significant improvement for patients and their physicians who are waiting for advice on whether a genomics test is an option for clarifying undiagnosed or rare diseases.

## FINANCIAL IMPLICATIONS

- This program was transferred to PHSA on June 1, 2018. In 2018/2019, when jointly administered by the Ministry of Health, Health Insurance BC and the PHSA, the program expenditures were approximately $4.1 million.[1]
- For 2019/20, PHSA program expenditures were approximately $4.3 million.
- The estimated expenditures for 2020/21 is $4.4 million.

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**Approved:**
January 27, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 2, 2021 - Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 15, 2021– Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] Health Sector Information, Analysis and Reporting, Ministry of Health; OOP_OOC Genetic and Lab Testing 2017_18 to 2019_20.xlsx (PAS#3000.0631)

# LEGISLATIVE SESSION - FACT SHEET

# Pan-Canadian Pharmaceutical Alliance (Brand and Generic Drugs)

## TOPIC

Pan-Canadian Pharmaceutical Alliance (pCPA) for Brand and Generic Drugs (formerly the "pan-Canadian *Pricing* Alliance"). This includes negotiations for Expensive Drugs for Rare Diseases (EDRD), biological and biosimilars entering the market.

## CURRENT SITUATION

- The pCPA continues to be an important alliance in which Canadian jurisdictions use to achieve greater value for drugs.
- Through ongoing feedback and collaboration with appropriate stakeholders, the pCPA continues to review and refine its processes, where required. Innovative Medicine Canada (IMC), member companies and others continue to dialogue with the pCPA to reduce the time to list their drugs.

## KEY FACTS

- The pCPA was originally established as the pan-Canadian Pricing Alliance in August 2010. It was created by the premiers of Canada though the Council of the Federation's Health Care Innovation Working Group. The aim was to achieve greater value for publicly funded drug programs and patients through the combined negotiating power of the provinces and territories (PTs); as well as to increase access to drug treatment options and consistency in listing decisions across PTs.
- In 2015, the alliance was formalized with the new name pan-Canadian Pharmaceutical Alliance (pCPA), a mandate and objectives were developed, a governance structure was implemented, and a secretariat was created to provide support to the member jurisdictions.
- In 2015, Quebec joined the alliance followed by the federal drug plans in 2016.
- pCPA member jurisdictions include public drug plan participation from: BC, Alberta, Saskatchewan, Manitoba, Ontario, Québec, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland & Labrador, Yukon, Northwest Territories, Nunavut, Non-Insured Health Benefits (NIHB), Correctional Services of Canada and Veterans Affairs Canada.
- The pCPA's mandate is to enhance patient access to clinically relevant and cost-effective drug treatment options. It serves this mandate by conducting collective, expert-informed, negotiations for drugs.
- By capitalizing on the combined negotiating power of drug plans across multiple provinces and territories, the pCPA objectives are to:
    - increase access to clinically effective and cost-effective drug treatment options;
    - achieve consistent and lower drug costs for PTs;
    - reduce duplication of effort and improve use of resources; and
    - improve consistency of decisions among PTs.
- In late 2019 (10 years after its creation), the pCPA conducted an in-depth assessment of the organization to inform how the pCPA is doing. The evaluation addressed pCPA's performance against its stated mandate, included a Strengths, Weaknesses, Opportunities and Threats analysis, and identified opportunities to strengthen its role, scope, mandate, capacity, governance and accountability[1].
- For Brand Drugs:
    - Since pCPA's inception until May 28, 2021, there have been 364 successful negotiations while 59 negotiations were closed without agreement[2].
- For Generic Drugs:
    - In 2014, the pan-Canadian Generic Tiered Pricing Framework (TPF) took effect and have resulted in substantial savings.
    - The TPF is comprised of 3 pricing tiers and applies to any generic product, where the current or previously available brand reference product was eligible for reimbursement by any pCPA jurisdiction.

[1] https://www.pcpacanada.ca/sites/default/files/pCPA%20Strategic%20Revitalization%20Summary.pdf
[2] https://www.pcpacanada.ca/negotiations

  - See *Generic Drug Prices Fact Sheet* for further details.
- With respect to biosimilar drugs, the pCPA endorses a clear and consistent national approach that encourages appropriate use of biologics aligned with the pCPA mandate to enhance patient access to clinically relevant and cost-effective drug treatment options.
  - In 2016**,** pCPA issued the *First Principles for Subsequent Entry Biologics (SEBs)* to guide negotiations and inform expectations for biologics and biosimilars.
  - In 2018**,** the *Biologics Policy Directions & pCPA Negotiations* was created to further guide and define the process on how biologic and biosimilar products will be negotiated and considered for reimbursement by Canada's public drug plans.
  - In 2019**,** pCPA created the *Review Process & pCPA Negotiations Update* which outlines the pCPA's negotiation process for biosimilars in response to Health Technology Assessment review changes.
  - pCPA engaged with the Canadian Agency for Drugs and Technologies in Health in November 2019, to conduct an extensive stakeholder consultation and engagement exercise on the subject of implementation and expanded use of biosimilars in Canada.
  - This consultation process provided an opportunity to understand how stakeholders including clinicians, patient group leaders, private payers, group purchasing organizations, and industry representatives, view the opportunity presented by biosimilars.
  - The final report National Consultation on the Use and Implementation of Biosimilars was released in February 2020 which summarizes the key themes and feedback pCPA received from its stakeholder consultation.

## FINANCIAL IMPLICATIONS

- Through collective negotiations, the pCPA has realized overall savings (as of March 31, 2019) of $1.52 billion annually for brand name drugs and $0.74 billion annually for generic drugs totaling $2.26 billion in annualized savings[3]
- According to the Canadian Institute for Health Information, the PTs government drug plans that participated in the alliance spent $15billion on prescription drugs in 2019.[4]

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**Approved:**
May 31, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 1, 2021- Christine Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
June 3, 2021- Brenda Rafter, obo Philip Twyford, ADM, Finance and Corporate Services Division

[3] pCPA Canada: https://www.pcpacanada.ca/about
[4] "Prescribed Drug Spending in Canada, 2020: A Focus on Public Drug Programs." *Canadian Institute for Health Information*. 2019.. Available Online: https://www.cihi.ca/sites/default/files/document/prescribed-drug-spending-in-canada-2020-report-en.pdf

# LEGISLATIVE SESSION - FACT SHEET

## Patented Medicine Prices Review Board - Amendments to Regulations

### TOPIC

The Patented Medicine Prices Review Board (PMPRB) has amended their regulations to improve Canadian pricing of patented drugs. The new regulations will be in effect on July 1, 2021 (previously January 1, 2021 and before that, July 1, 2020).

### CURRENT SITUATION

- In November 2019, PMPRB released its proposed guidelines on how they intend to implement their changes to the regulations.
- On June 19, 2020 the PMPRB issued a new set of draft guidelines following a consultation with stakeholders.
- The June 2020 draft guidelines are expected to result in pricing that will be less favorable for payers than the November 2019 draft guideline.
- The new guideline was published on October 23, 2020.
- The coming into force date of the new guidelines was delayed by 12-months to July 1, 2021 (from January 1, 2021 and before that, July 1, 2020).
- In February 2021, the PMPRB sought feedback on 2 changes to the new guideline: 1) update the definition of Gap medicines, and 2) reducing the compliance timeline for Grandfathered and Gap medicines.
- Amended guidelines were released on March 2021 to reflect feedback received in February 2021.
- In April 2021 the PMPRB revised the compliance deadline by 2 compliance periods effectively delaying implementation of the new maximum list price for grandfathered and gap medicines until July 1, 2022. Cited rationale for the delay was due to the ongoing COVID-19 pandemic.[1]
- The pharmaceutical industry and some patient advocacy groups are opposed to the new regulations; as they argue that PMPRB does not have the constitutional authority to regulate the pricing of medicines, they also claim that the changes will slow and limit Canadians' access to new breakthrough medicines.

### KEY FACTS

**Background**

- PMPRB is an independent, quasi-judicial, consumer protection agency that carries out its mandate at arms length from the federal Minister of Health. PMPRB was established in 1987 to ensure that the prices of patented drugs sold in Canada are not excessive through three legal instruments which include: Patent Act, Patented Medicine Regulations, and Guidelines.

**Patented Drug Pricing Issues in Canada**

- Canada pays the third-highest list prices on patented drugs in Organization for Economic Cooperation and Development (OECD).
- Rapid growth in high-cost drugs is accounting for an increasingly significant share of spending but covers only a minority of claimants. High-cost patented drug are used by only 1% of Canadians but accounted for 30% of 2017 sales, up from only 8% in 2006. In 2017, 5 of the top 10 selling drugs had an average annual treatment cost exceeding $10K.[2]
- In the last 5 years, the fastest growing segment of the market is high cost drugs at 13%, of which expensive drugs for rare diseases (EDRDs) are growing at 33%.[3] EDRD's typically are priced at over $100,000 per year of treatment per person and treat rare diseases.

**Current PMPRB Regulatory Framework Issues**

- Current regulatory framework consists of a basket of seven countries – the PMPRB7 – and is made up of premium priced countries that includes the United States, an international pricing outlier.
- PMPRB price review is based on publicly available list prices, which are increasingly not reflective of the true price net of confidential rebates or discounts.

[1] https://www.canada.ca/en/patented-medicine-prices-review/services/consultations/notice-comment-definition-gap/decision-definition-gap-medicines.html
[2] https://www.canada.ca/content/dam/pmprb-cepmb/documents/consultations/draft-guidelines/presentation-dec10-en.pdf
[3] https://www.canada.ca/content/dam/pmprb-cepmb/documents/consultations/draft-guidelines/presentation-dec10-en.pdf

- Internal and external price referencing are insufficient tools to regulate the new wave of very high-cost medicines that can potentially represent a large share of the market.
- All medicines are subject to the same level of regulatory scrutiny, regardless of the high pricing risk.
- PMPRB sets ceiling prices for medicines at market introduction and they do not reassess over time to ensure that they remain reasonable or non-excessive.

**PMRPB Changes to Regulations:**

- On August 7, 2019, amendments to the Patented Medicines Regulations were changed to better manage excessive Canadian drug prices. On August 9, 2019, the BC Minister of Health expressed support of PMPRB changes to its regulations. The changes will help provide a more sustainable drug plan by allowing the limited health-care dollars to be used more efficiently.[4]
- On November 21, 2019, PMPRB released its proposed guidelines on how they intend to implement their changes to the regulations. On the same date, PMPRB announced a stakeholder consultation period, originally ending on January 31, 2020 but was extended to February 14, 2020.
- On June 1, 2020, PMPRB announced a delay of the regulations effective date to January 1, 2021 (from July 1, 2020).
- A new set of draft Guidelines was published on June 19, 2020, followed by a 30-day consultation period with stakeholders.
- The new guideline was published on October 23, 2020.
- As result of coming into force delay and feedback received in February 2021, amended guidelines are released in March 2021:
    - The definition of Gap medicines is amended – the date of first sale has been extended to the new coming-into-force date of July 1, 2021. (from January 1, 2021). Drug Identification Number assignment date to define Gap medicines is starting from August 21, 2019 to July 1, 2021.
    - Compliance timeline for Grandfathered and Gap medicines remain unchanged – Patentees must comply within two reporting periods for Grandfathered or Gap medicines.
- Major PMPRB Amendments include:
    1. Updating the basket of countries used to set the benchmark pricing (PMPRB7 to PMPRB11)
        - Current: PMPRB7 – France, Germany, Italy, Sweden, Switzerland, UK, US. However, US and Switzerland are ranked first and second as the highest list prices on patented drugs in OECD.[5]
        - Proposed PMPRB11 - replaces the US and Switzerland with Australia, Belgium, Japan, Netherlands, Norway, Spain.
    2. Consider the value and the market size of a medicine when setting the maximum price.
    3. Regulating at the level of the actual prices being charged by patentees in Canada and not just the transparent manufacturer list prices.
- PMPRB expects these amendments will not reduce or delay access to new innovative medicines, nor will it adversely impact the levels of R&D investments in Canada as several countries with lower prices have faster access to new medicines than Canada.
- Despite the new amendments having certain financial impact on the pharmaceutical industry, PMPRB expects Canada to continue to be a highly profitable market for the industry.
- Certain aspects of the new regulations are still being actively challenged at the courts but it's not expected to stop the new amendments to come into force.

## FINANCIAL IMPLICATIONS

PMPRB estimates that Canadians are expected to save roughly $13.2 billion over 10 years as a result of the proposed regulatory changes to protect Canadians from excessive drug prices.[6]

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**Approved:**

February 7, 2020 - Brenda Rafter obo Dave Boychuk, CFO/ Philip Twyford, ADM, Finance and Corporate Services Division
May 31, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

[4] https://news.gov.bc.ca/releases/2019HLTH0117-001581
[5] https://www.canada.ca/content/dam/pmprb-cepmb/documents/consultations/draft-guidelines/presentation-dec10-en.pdf
[6] https://www.canada.ca/content/dam/pmprb-cepmb/documents/consultations/draft-guidelines/presentation-dec10-en.pdf

# LEGISLATIVE SESSION - FACT SHEET

# Pay-for-Performance Model for Drug Reimbursement

## TOPIC

- With the rising healthcare costs, payers are seeking innovative strategies for cost containment of drug expenditures. One such approach is the Pay-for-Performance (PfP), or also known as Outcomes-Based Agreements (OBA) model.
- The underlying philosophy behind this model is that the payer only reimburses the drugs for those patients for whom the drug therapy is effective.

## CURRENT SITUATION

- PfP can be a viable model for funding drugs and if used properly it can be cost-effective for achieving higher value for drug expenditures. However, to achieve this, the various barriers and limitations to PfP need to be overcome, which includes a means by which to collect reliable real-world evidence of a drugs effectiveness.
- The PfP model is still in its infancy and has not yet gained significant traction in the Canadian health market. A jurisdictional scan of several countries including the US, UK and China showed there are both successes and challenges in the implementation of PfP.[1,2,3,4]
- The Canadian Pharmacists Association has outlined recommended principles for the development of a successful PfP program.[5]
- The BC Ministry of Health along with the pan-Canadian Pharmaceutical Alliance will continue to explore ways to maximize the utility of PfP models.
- On October 26, 2020, the Institute of Health Economics established the Health Technology Innovation Platform a 3-year public/private initiative, to explore this concept.[6] BC is an active participant on this collaboration, along with Alberta, Ontario, Health Canada and the Canadian Agency for Drugs and Technologies in Health. The work is supported through funding from Boehringer Ingelheim, GlaxoSmithKline and Roche Canada.

## KEY FACTS

- The cost of prescription drugs has been increasing and the PfP model could be one viable alternative for payers and manufacturers to improve cost-effectiveness and cost containment in the health system.
- One type of PfP model can be structured to allow payers to receive compensation from drug manufacturers for drugs that are ineffective based on their expected clinical outcomes. By incorporating such reimbursement agreements into negotiations with manufacturers, the payers may not be financially liable, or may only be partially liable, if the drugs do not achieve the intended outcomes.
- PfP models are not a substitute for the lack of good clinical evidence or cost-effectiveness measures; these factors remain crucial in determining whether a drug should be listed.[7]
- The implementation of a PfP program requires collaboration among various stakeholders such as pharmacists, physicians, government professionals, patients, citizens, vendors/digital eco-systems, and other health care providers/stakeholders. It may be challenging to engage all the stakeholders with diverse perspectives and competing priorities across our health system.

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[1] Pharmaceutical technology. 2017. Pay-for-performance deals for pharmaceuticals continue to gain momentum in the US. Available at: < https://www.pharmaceutical-technology.com/comment/commentpay-for-performance-deals-for-pharmaceuticals-continue-to-gain-momentum-in-the-us-5755103/>

[2] Yip, W., Powell-Jackson, T., Chen, W., Hu, M., Fe, E., Hu, M., ... & Hsiao, W. C. (2014). Capitation combined with pay-for-performance improves antibiotic prescribing practices in rural China. *Health affairs*, *33*(3), 502-510.

[3] Hamel, M. B., Roland, M., & Campbell, S. (2014). Successes and failures of pay-for-performance in the United Kingdom. *The New England journal of medicine*, *370*(20), 1944.

[4] Millett, C., Gray, J., Bottle, A., & Majeed, A. (2008). Ethnic disparities in blood pressure management in patients with hypertension after the introduction of pay-for-performance. *The Annals of Family Medicine*, *6*(6), 490-496>

[5] Canadian Pharmacists Association. Available at: < https://www.pharmacists.ca/advocacy/pharmacy-pay-for-performance-principles/>

[6] Innovative Approaches for Pharmaceutical Management to be Explored in Public/Private Collaboration. Available at: https://www.ihe.ca/news/updates/innovative-approaches-for-pharmaceutical-management-to-be-explored-in-public-private-collaboration

[7] Lun, E. Real World Evidence for Coverage Decisions. Canadian Association for Healthcare Reimbursement (CAHR) Western Day (Vancouver) Presentation. Jan 22, 2019.

- Pharmaceutical companies are not prepared to accept prices that do not reflect innovation value and expensive research and development investments that they are bringing to patients, the healthcare system, and the broader economy.[8]
- Payers want value for money and what is best for their patients. A PfP program could provide an additional way for payers to seek value for their money by ensuring that public taxpayer dollars are spent on drugs that are effective based on predefined, measurable, and achievable outcomes.

Key Features of a successful PfP Model

- A successful PfP model requires access to robust data across the health sector (enabled by integrated systems) and formal well-defined consensus value metrics. These value attributes (e.g. the outcome or performance variables of interest) must be collected, measured, valued, aggregated and converted to evaluate whether the value metric was achieved. The price must be linked explicitly by formula to the value metric of the program. In addition, a clear payment or reimbursement mechanism must be developed.
- Another feature is defining and measuring clinically relevant and evidence-based outcomes to determine if the drug is effective. For example, if a diabetes drug is supposed to lower plasma glucose levels and it fails to do so, then a rebate to the payer could be justified.

Challenges in Developing PfP Models[9]

- Among payers and pharmaceutical companies, there may be difficulty in obtaining access to all required data/information, reaching consensus on value metrics and price thresholds (the highest price or reward for achieving a value metric and lowest price or penalty for not achieving it).
- From a financial perspective, payers may want to measure the value as early as possible for some outcomes, while pharmaceutical companies may want to ensure that adequate time has passed for value to be determined. There is a lack of well-validated tools to measure value.
- Another potential barrier to PfP may be defining measurable outcomes for disease preventative drugs especially when there are other confounding factors that could also positively or negatively impact the expected outcomes such as: genetics, lifestyle, comorbidities etc.
- It would also be difficult to develop a standardized way to capture the same metrics and outcomes.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
January 21, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

[8] Towse, A., Garrison, L., & Puig-Peiró, R. (2011). The use of pay-for-performance for drugs: Can it improve incentives for innovation?. In *Incentives for Research, Development, and Innovation in Pharmaceuticals* (pp. 69-80). Springer Healthcare, Madrid.
[9] Deloitte. Issue Brief: Value-based pricing for pharmaceuticals: Implications of the shift from volume to value. Available at: < https://deloitte.wsj.com/cfo/files/2012/09/ValueBasedPricingPharma.pdf>

# LEGISLATIVE SESSION - FACT SHEET

## PharmaCare Overview

### TOPIC

The PharmaCare program helps eligible BC residents with the costs of eligible prescription drugs, designated medical supplies, and pharmacy services through 12 drug plans. The largest is the income-based Fair PharmaCare Plan, launched in 2003.

### CURRENT SITUATION

Fair PharmaCare Enhancements

- On February 9, 2018, the Minister of Health announced that $105 million would be invested in Fair PharmaCare over 3 years.
- The investment reduces or eliminates deductibles and family maximums for approximately 240,000 lower income families. This was the first time that the program had been changed since its inception.
- As of January 1, 2019, all families with net annual incomes up to $30,000 are no longer required to pay a deductible. Fair PharmaCare co-payments have also been lowered for all families with net incomes of up to $45,000 and eliminated for families with a net income of up to $13,750.

Impact of Enhancements (2019 calendar year)

- An additional 79,718 families earning up to $45,000 received paid benefits in 2019; before these enhancements these families would not have received a paid benefit.[1]
- A total of 215,546 families earning up to $45,000 received an increased benefit in 2019 as a result of the enhancements.[1]
- Single women earning up to $45,000 benefitted most from the Fair PharmaCare enhancements, representing 52% of the additional beneficiaries.[1]
- The total amount attributable to the Fair PharmaCare Enhancements for the 2019 calendar year was $31.6 million.[1]

Impact of COVID-19

- Under Fair PharmaCare, a family's level of coverage is based on their family net income from 2 years ago. If a family experiences a decrease of 10% or more in family net income in the current year or previous year, they can apply for an income review.
- Due to COVID-19-related job loss across BC, it was anticipated the number of Fair PharmaCare income reviews would increase, creating new administrative challenges.
- Income review application rate increases could continue into 2021 as deductibles for 2021 are based on 2019 income levels, before the COVID-19-related income declines began.
- A separate income review application system for families who lost employment due to the COVID-19 emergency was developed and became available on June 22, 2020. It includes both a digital and paper-based option.
- In 2020, the number of income review applications received by HIBC was not higher than in 2019, however; the number of applications in the first two weeks of 2021 is higher than during the same period in the previous 2 years.

### KEY FACTS

- PharmaCare is BC's drug insurance program that provides financial assistance to BC residents for eligible prescription drugs and medical supplies including:
    - drugs prescribed by physicians, surgeons, dentists, optometrists, midwives, podiatrists, naturopathic physicians and nurse practitioners;
    - insulin, insulin pumps, needles, syringes, insulin pump supplies and blood glucose monitoring strips for people with diabetes; and
    - certain ostomy supplies, permanent prostheses and children's orthotic devices.

[1] PharmaNet, Healthideas, Health Sector Information, Analysis and Reporting, May 6, 2020

- On October 1, 2017, First Nations Health Authority (FNHA) clients joined the BC PharmaCare program. On that date, most FNHA clients who had been receiving benefits through Health Canada's Non-Insured Health Benefits program became eligible for coverage of prescribed medications and pharmacy services under PharmaCare's First Nations Health Benefits Plan W (See First Nations Health Benefits Fact Sheet for more information).

Evidence-based Drug Coverage Decisions

- PharmaCare has a rigorous drug review process for determining whether new drugs should become benefits.
- BC's outcome-based approach to drug coverage helps control spending while ensuring that patients have access to the drugs they need to improve their health.

## FINANCIAL IMPLICATIONS

- In 2019/20, PharmaCare expenditures were approximately $1.233 billion. PharmaCare's budget for 2020/21 is $1.411 billion.[2] These amounts include benefits to British Columbians as well as additional payments and recoveries.

| Plan | Coverage Expenditures 2019/20 | Approximate # of Beneficiaries 2019/20 |
|---|---|---|
| Fair PharmaCare (Plan I)<br>($571.03 million regular; $137.15 million enhanced assistance) | $708.17 million[3] | 517,000[3] |
| Residential Care (Plan B) | $37.75 million[3] | 32,000[3] |
| Recipients of BC Income Assistance (Plan C) | $399.42 million[3] | 185,000[3] |
| Cystic Fibrosis (Plan D) | $2.45 million[3] | 400[3] |
| Children in the At Home Program (Plan F) | $6.64 million[3] | 3,000[3] |
| Psychiatric Medications (Plan G) | $53.63 million[3] | 50,000[3] |
| Medication Management Services (Plan M) | $24.32 million[3] | 1,022,000[3] |
| BC Palliative Care Drug Plan (Plan P) | $20.70 million[3] | 15,000[3] |
| Smoking Cessation (Plan S) | $13.76 million[3] | 75,000[3] |
| Universal, no-cost coverage for Mifegymiso (Plan Z) | $1.22 million[3] | 4,000[3] |
| The BC Centre for Excellence in HIV/AIDS (Plan X) | $103.14 million[2] | 11,000[2] |

- In fiscal year 2019/20, PharmaCare:
  - accounted for approximately 5.26% of Ministry of Health expenditures;[2,4] and
  - had an average cost per capita of $243.[2,4]
- Cost drivers for PharmaCare include:
  - increasing use of drug treatments outside hospitals;
  - introduction of newer, more expensive drug therapies; and
  - demand increases due to an aging population and an increasing number of people living with chronic diseases.

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**Approved:**
January 29, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 23, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
April 6, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[2] Financial and Corporate Services, Ministry of Health.
[3] PharmaNet, Health Sector Information, Analysis, and Reporting Division, June 26, 2020.
[4] Public Accounts figure of Ministry of Health expenditure $23,449 billion and PharmaCare expenditure $1,233 million divided by 5.071 million, BC Statistics Population estimates for 2019.

# LEGISLATIVE SESSION - FACT SHEET

## *Pharmaceutical Services Act*

### TOPIC

The *Pharmaceutical Services Act* (PSA) establishes a legislative foundation for the PharmaCare program.

### CURRENT SITUATION

The regulations under the PSA are amended from time to time, as program needs change.

### KEY FACTS

- The PSA came into force on May 31, 2012 and is designed to enshrine the provision of pharmaceutical services for BC in legislation.
- Before May 31, 2012, the PharmaCare program was administered via an extensive policy framework which could be seen to be part of the guidelines issued by the Minister under the *Continuing Care Act.*
- The PSA creates authorities such as establishing drug plans and formularies, managing the enrolment of beneficiaries and providers, and managing clinical access to PharmaNet information. It also contains provisions for regulating drug pricing.
- Under the PSA, four regulations came into force by May 2015:
    - Drug Price Regulation;
    - Provider Regulation;
    - Drug Plans Regulation; and
    - Information Management Regulation.
- The Drug Price Regulation came into force on April 1, 2013. Under this regulation, the Maximum Accepted List Price (MALP) is set at 25% of the brand-name drug price for oral solid generic drugs to be listed on the PharmaCare formulary, with the exception of provisional drugs.
- The Provider Regulation came into force on December 1, 2014. This regulation focuses on the enrolment of providers (e.g., community pharmacies and device providers), duties of providers and enforcement. The goal of this regulation is to codify the duties of providers enrolled in the PharmaCare program and enhance existing provisions regarding criteria for enrolment.
- The Drug Plans Regulation came into force on June 1, 2015. This regulation contains provisions which set out the PharmaCare drug plans, including enrollment of beneficiaries in drug plans, and drug plan deductibles and co-payments. With respect to beneficiaries, the regulation addresses:
    - entitlement to benefits under the PharmaCare program;
    - coordination of the assessment of claims and payment of benefits with insurers and other reimbursement programs;
    - limits and conditions on a beneficiary's entitlement to benefits; and
    - cancellation of a beneficiary's enrollment in one or more drug plans.
- The Information Management Regulation came into force on June 1, 2015. It regulates access to the PharmaNet system and collection, use and disclosure of personal information in PharmaNet for specified purposes. The goal of this regulation is to support expanded and enhanced use of PharmaNet by authorized users while implementing accountability for information access and use at an individual level. It also provides for information-related audit and sanctions for misuse of PharmaNet or its information. All users will need to (re)enroll with the Ministry by April 1, 2022.
- Revisions to the Information Management Regulation are being drafted to support site registration and enhancements to user enrollment, and to address gaps in the existing regulation. They also include ministerial orders to implement the enrollment onboarding schedule for users grandfathered under the current regulation.

### FINANCIAL IMPLICATIONS

N/A

**Approved:**

January 25, 2021 – Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Pharmacogenomics – Current State

## TOPIC

Pharmacogenomics (PGx) is a rapidly evolving area of precision medicine focused on individual responses to medications (e.g. cardiac, antidepressants, blood thinners), and the extent to which these responses are attributed to genetics.

## CURRENT SITUATION

- The Ministry of Health provides funding to support some limited PGx testing through regional health authority budgets and clinical research.
- Multiple vendors are selling direct-to-consumer (DTC) PGx tests, however, there has been very little uptake by publicly funded health systems due to a lack of longitudinal clinical data, as well as, difficulty in integrating genetic information into prescription practices and guidelines for clinicians.
- Multiple commercial and academic groups engaged in BC have been promoting PGx as a precision medicine initiative that can dramatically improve patient health outcomes and reduce Adverse Drug Reactions (ADRs). Current patient pay/DTC PGx tests available within BC include:
    - **GenXys - TreatGx$^{plus}$:** LifeLabs partnered with GenXys Health Care Systems in 2017 to offer PGx testing at LifeLabs locations across Canada. Their TreatGx$^{plus}$ test is patient pay (approx. $500 per patient) and requires a requisition from an authorized healthcare provider. The TreatGx$^{plus}$ test claims to identify which medications and dosages are likely to be best suited to an individual for a wide variety of conditions.[1]
    - **Dynacare – Genecept Assay®:** Dynacare is one of the largest medical diagnostic laboratories in Canada. Their Genecept Assay® test is patient pay (approx. $495 per patient)[2] and requires a requisition from an authorized health provider. The Genecept Assay® PGx test focuses on psychiatric drugs (e.g., mood or anxiety disorders) and claims to indicate which drugs should work as intended without ADRs.
    - **MyDNA – RxOME:** RxOME Pharmacogenomics Canada Inc., is a joint venture between the BC Pharmacy Association and MyDNA, a genetic testing and interpretation service provider. Initiated in 2017, the MyDNA PGx test is provided at more than 110 pharmacies across BC as a DTC/patient pay PGx test (approx. $150-$200 per patient). The MyDNA PGx test claims to identify which medications are likely to be best suited to an individual, for a variety of conditions.[3]
    - **BC Digital Technology Supercluster:** launched in March 2019, this partially federally funded program includes a PGx project called "Tailored Health - Pharmacogenetics" led by Telus Health and in partnership with GenXys, LifeLabs and Genome BC.[4,5]
- While PGx is a promising personalized-medicine tool for British Columbians, the Ministry's preliminary economic analysis, extensive literature reviews and environmental scans, have indicated that the potential impact of publicly funded PGx in reducing ADRs, treating disease, and improving long-term patient outcomes requires on-going analysis, and more longitudinal data than exists today.
- The Ministry is working with the Provincial Health Services Authority, clinicians, researchers, and industry to assess PGx products and benefits to patients.
- The Ministry is also engaged in two other PGX initiatives:
    - **Ministry Policy Framework** – a longer-term evidence-based policy framework that considers the appropriate use and implementation of PGx in the province.
    - **Economic Modeling** – initially working with Deloitte, began a process in 2019 to assess the health-cost effectiveness and clinical utility of existing international PGx products through the development of an iterative economic modeling tool.

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[1] https://www.lifelabsgenetics.com/product/treatgxplus-service/
[2] https://www.dynacare.ca/print-a-form.aspx#Genecept (Payment Authorization Form)
[3] https://www.bcpharmacy.ca/resource-centre/health-issues/pharmacogenomics
[4] https://www.digitalsupercluster.ca/wp-content/uploads/2019/09/Tailored-Health-Pharmacogenetics.pdf
[5] https://tinyurl.com/yzekqalw

- To date, Health Canada has not approved any PGx products, and the USA's Food and Drug Administration (FDA) has only approved one product for marketing in the USA. In 2019, the FDA warned and sanctioned multiple companies against making unsubstantiated claims for their products and has warned that unapproved products could have *"potentially serious health consequences for patients"*.[6]

## KEY FACTS

- The combination of an individual's genetic make-up and environmental factors determines whether they respond well or poorly to drug treatment. Examining the genetics-only component of drug response is known as pharmacogenomics or pharmacogenetics.
- PGx may help to reduce the number of ADRs and to help avoid ineffective treatments, improve the accuracy of drug dosages, and has the potential to result in decreased healthcare costs and hospital admissions.
- Data indicates that approximately 1 in 9 emergency room visits in BC are due to ADRs with 70% preventable and 30% repeat ADRs. This equates to approximately 275,000 emergency department visits/year[7]. However, it remains unclear how many of these, if any, could be prevented using a PGx test.

## FINANCIAL IMPLICATIONS

- Provincial funding is also provided to help better understand the value of broader PGx. The GO-PGx Large Scale Applied Research Project (LSARP) is a Provincial Health Services Authority based research project which began in 2017 that is supported by Genome Canada and Genome BC. It aims to reduce ADRs in childhood cancer patients by developing strategies to better integrate PGx into the healthcare system and determine which predictive PGx tests are most effective for patient populations. This project is funded by Genome Canada and Genome BC at approximately $10 million over five years.
- Since 2001, the Province has contributed $287.53 million (including $29 million provided by the Ministry in March 2019) to support Genome BC. Of this total amount, the Ministry has contributed $140.0 million.

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**Approved:**
January 27, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 9, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
March 15, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

[6] https://tinyurl.com/ydola6md
[7] https://www.bcemergencynetwork.ca/innovation_program/preventing-adverse-drug-events/

# LEGISLATIVE SESSION - FACT SHEET

## Pharmacy Medication Management Services

### TOPIC

Overview of medication management services covered by PharmaCare.

### CURRENT SITUATION

- PharmaCare covers the following medication management services provided by community pharmacists to eligible residents of BC:
    - Clinical services (i.e., prescription adaptations and renewals);
    - Administration of publicly funded vaccines; and
    - Medication Review Services.
- There is a concerted effort by the broader pharmacy community to promote and seek support from governments across Canada for more clinical pharmacy services to fill gaps, improve patient outcomes, contain costs and ensure the sustainability of the Canadian healthcare system.
- The BC Pharmacy Association has proposed that during the COVID-19 pandemic, pharmacists should be able to provide medication reviews to patients via telephone or videoconference. Currently medication reviews are only eligible for PharmaCare reimbursement when they are completed in-person.Advice/Recommentati

Advice/Recommentations

### KEY FACTS

Clinical Services

- An amendment to the *Health Professions Act* in 2008 enabled pharmacists to adapt some prescriptions, beginning in January 2009, and since then pharmacists in BC have had the ability to submit claims to PharmaCare for the provision of clinical services that result in a prescription adaptation.
- Fees are only paid for prescription adaptations as defined by the College of Pharmacists of BC Professional Practice Policy 58 and include:
    - Renewing a prescription;
    - Changing the dose, formulation, or regimen of a prescription; and
    - Making a therapeutic drug substitution within the same therapeutic class (Reference Drug Program Category). However, effective May 7, 2020, PPP-58 was amended to permit therapeutic substitutions outside of RDP categories in the event of confirmed shortages during the COVID-19 public health emergency.
- PharmaCare reimburses pharmacies a $10 fee for a prescription renewal or for changing a dose, formulation, or regimen and a $17.20 fee for making a therapeutic substitution.
- Any BC resident requiring a prescription adaptation as defined by the College of Pharmacists of BC Professional Practice Policy 58 is eligible for the service at no charge.

Administration of Publicly Funded Vaccines

- Further amendment to the Act in 2009 granted pharmacists the authority to administer subcutaneous, intra-dermal and intra-muscular injections for immunization and for the treatment of anaphylaxis to residents 5 years of age and older in BC. An amendment to the Pharmacists Regulation, effective December 3, 2015, expanded pharmacists' scope of practice to include administering vaccines intranasally.[1]
- As of August 28, 2020, 4,203 pharmacists and 344 pharmacy students in BC have been authorized by the College of Pharmacists of BC to administer vaccinations.[2]
- Authorized pharmacists have full access to vaccine products for sale and administration within the private payer system and increasing access to publicly funded vaccines for administration to eligible BC residents.

[1] Province of British Columbia. Regulation of the Minister of Health. Health Professions Act. December 3, 2015.
[2] College of Pharmacists of British Columbia. 2019/20 Registration Statistics. August 28, 2020.

- As of December 2020, pharmacists have access to 22 product groups of publicly funded vaccines for administration to eligible BC residents under specific circumstances.[3]
- PharmaCare reimburses pharmacies a $12.10 fee per publicly-funded vaccination administered by injection or intranasally by an authorized pharmacist to an eligible BC resident. Effective September 1, 2020, the fee increased from $10 as part of the government's priority initiative to increase immunization rates (principally influenza immunization rates) during the COVID-19 pandemic. These claims are tracked in PharmaNet.[4]

Medication Review Services

- As of April 2011, pharmacists in BC may submit claims to PharmaCare for the provision of medication review services.
- A medication review is a one-on-one, in-person appointment between a patient and pharmacist in which medication information is gathered, validated, summarized and reviewed.
- The goals of the medication review are to: increase patient understanding of what medications are being taken, why they are being taken and how they are to be taken for optimal benefit; create a medication management plan to address any issues, when appropriate; and create a "Best Possible Medication History" that improves communication, maintains continuity of care and reduces the risk of drug therapy problems.
- There are 3 types of medication review services eligible for payment:
    - Medication Review—Standard ($60);
    - Medication Review—Pharmacist Consultation ($70); and
    - Medication Review—Follow-Up ($15).
- Patients must have at least 5 different qualifying medications on their PharmaNet profile in the last 6 months and demonstrated clinical need for service to be eligible.
- The Ministry of Health and the BC Pharmacy Association worked together to clarify and revise the Medication Review Services policy to transform the policy into a clearer, and more useful document for pharmacists who deliver these services to British Columbians. The revised policy came into effect April 1, 2014.

Reimbursement Limit

- PharmaCare will pay a maximum of $70 per patient, per day for a combination of clinical services, administration of vaccines and medication reviews, from the same pharmacy.

## FINANCIAL IMPLICATIONS

The total amount paid by PharmaCare in fiscal 2019/20 for medication management services was:

- $2.88 million for clinical services[5];
- $8.55 million for the administration of publicly funded vaccines[5]; and
- $12.81 million for medication review services[5].

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**Approved:**

February 2, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 9, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 12, 2021 - Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[3] BC Ministry of Health. Publicly Funded Vaccines. Updated December 2020.
[4] Section 8.10 - Payment for Publicly Funded Vaccinations. PharmaCare Policy Manual 2012.
[5] PharmaNet, Health Sector Information, Analysis and Reporting Division, Ministry of Health, July 2, 2020.

# LEGISLATIVE SESSION - FACT SHEET

## Pharmacy Remuneration

### TOPIC

PharmaCare makes payments to pharmacies on behalf of beneficiaries for eligible drugs, medical supplies and devices, and related services.

### CURRENT SITUATION

PharmaCare remunerates pharmacies in a variety of manners to ensure that: (1) British Columbians have access to the drugs and pharmacy services they need to achieve positive health outcomes and (2) pharmacists are supported to work to their full scope of practice, to the greatest degree possible.

### KEY FACTS

- Community pharmacies in BC are commercial businesses that set their drug prices and dispensing fees based on the marketplace; therefore, there can be a wide variation in what pharmacies charge individuals for prescription drugs and dispensing fees. Prices and fees charged are often greater than the maximum reimbursed by PharmaCare.
- Under the Full Payment Policy, when a patient is receiving 100% coverage by PharmaCare, pharmacies are not permitted to charge the patient over and above the maximum amount reimbursed by PharmaCare.

**Pharmacy Remuneration Currently Provided for:**

Drug Cost Reimbursement

- PharmaCare reimburses generic and brand name drug costs eligible for PharmaCare coverage up to a maximum price based on the manufacturer's list price plus an 8% mark-up for most drugs (5% or less mark-up for high cost drugs).
- On March 1, 2017, the maximum markup on certain high cost Hepatitis C drugs was reduced to 2%. Reimbursement may also be subject to the Reference Drug Program, the Low Cost Alternative Program or other PharmaCare pricing program or policy.
- PharmaCare reimburses the lesser of the drug costs adjudicated under all pricing programs and policies applicable to a particular drug.

Medical Supply and Device Cost Reimbursement

- PharmaCare reimburses eligible medical supply and device costs (e.g., insulin pumps and supplies, blood glucose test strips, prostheses, orthoses, etc.).
- Reimbursement may be limited to a maximum price based on the list price of the product, the pharmacy's actual acquisition cost for the product, or the pharmacy retail price for the product.

Dispensing Fees

- Effective July 10, 2011, PharmaCare reimburses a dispensing fee to a maximum of $10 for each eligible drug dispensed.
- Dispensing fees for less than a 28-day supply of a medication are governed by the Frequency of Dispensing policy and may be ordered by the prescriber or the pharmacist to address specified patient safety and/or compliance concerns.

Plan B Capitation Payments

In lieu of dispensing fees, a payment of $43.75 per month per serviced bed is paid for clinical services provided by contracted pharmacies for the benefit of patients residing permanently in residential care facilities.

Clinical Service Fees

- PharmaCare pays a clinical service fee in addition to the dispensing fee when a pharmacist renews or adapts a prescription for a BC resident. There is no charge to BC residents for these services.
- Pharmacies receive $10 for renewing and/or changing the dose, formulation or regimen of a prescription and $17.20 for making a therapeutic substitution within the same therapeutic class.

Medication Review Services

Pharmacies receive between $15 and $70 for providing a medication review, a patient-care service that seeks to improve health outcomes by enhancing a patient's understanding of their medication regimen.

Methadone Maintenance Payment Program (MMPP) Fees

Pharmacies enrolled in the MMPP are paid the dispensing fee plus an interaction fee of $7.70 for each dispense of methadone involving direct interaction with the patient.

Special Services Fees

When a pharmacist chooses not to dispense a prescription for reasons such as a drug-to-drug interaction or suspicion of multi-doctoring, they may be entitled to claim a Special Services Fee equal to twice the dispensing fee that would have been paid had the dispense been made.

Rural Incentive Program

- The Rural Incentive Program (RIP) assists low volume (fewer than 1,700 claims per month) rural pharmacies and telepharmacies to continue providing services by paying a subsidy for each prescription dispensed.
- The subsidy is scaled to provide greater assistance to the lowest volume pharmacies and currently ranges from $3 to $10.50 per claim.

Pharmacist Vaccinations

Pursuant to the Immunize BC strategic framework, PharmaCare pays authorized pharmacists $12.10 for each publicly-funded vaccination they inject or administer intranasally (only FluMist). Effective March 31, 2021, PharmaCare pays pharmacies $18 for each dose of AstraZeneca/COVISHIELD vaccine administered.

Compounding

For compounded prescriptions eligible for PharmaCare coverage, PharmaCare reimburses the costs of eligible ingredients, a dispensing fee, and a fee for preparing the compound, which ranges from $15 to $40 depending on the type of compounded prescription being prepared.

Medical Assistance in Dying

- Medical Assistance in Dying (MAiD) regimens dispensed by community pharmacies are 100% covered by PharmaCare.
- Pharmacies are reimbursed a $60 service fee for dispensing an oral MAiD regimen and $100 for an intravenous MAiD regimen.

Biosimilar Patient Support Fee

- Launched in 2019, the biosimilars initiative policy switches patients from originator biologics to less expensive biosimilars.
- During the initiative, PharmaCare offered a $15 patient support fee to pharmacies for identifying affected patients and providing information to them.
- PharmaCare paid 8,490 pharmacy biosimilar support fees during the initial switching period.

## FINANCIAL IMPLICATIONS

Pharmacy remuneration in fiscal year 2019/20 (in $ millions):

| Drug Costs | Dispensing Fees | Plan B Fees | RIP | Clinical Service Fees | Medication Reviews | Methadone Interaction Fees | Special Services Fees | Vaccinations | Total |
|---|---|---|---|---|---|---|---|---|---|
| 975.11 | 256.15 | 12.51 | 1.65 | 2.88 | 12.81 | 19.18 | 0.22 | 8.55 | 1,289.06 |

Source: PharmaNet, Health Sector Information, Analysis and Reporting, September 8, 2020.
Compounding fees, and medical supply and device costs are included in the drug cost total.

**Approved:**

February 9, 2021 - Christine Voggenreiter, obo Martin Wright, Health Sector Information, Analysis & Reporting Division
February 11,2021 - Peter Klotz obo Philip Twyford, Finance and Corporate Services Division
June 14, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

# PharmaNet

## TOPIC

PharmaNet is a provincial network that links BC health care practitioners and all community pharmacies to information systems to promote patient medication safety and provide real-time adjudication of PharmaCare claims.

## CURRENT SITUATION

- PharmaNet was implemented in 1995. In 2020, PharmaNet processed over 87 million dispenses and flagged over 378,000 serious drug interactions, assisting pharmacists in identifying and warning patients about potentially harmful medication interactions and unintended duplications.[1]
- There are 633 sites registered for Health Authority Facility Access to PharmaNet, including 117 sites registered for Emergency Department Access to PharmaNet.[2]
- There are 3,673 active community physicians and 173 active nurse practitioners that have Community Health Practice Access to connect to PharmaNet.[3] The number of active community physicians is lower than previously reported as we have de-activated several accounts that were not used.

## KEY FACTS

- Provincial legislation requires BC community pharmacists enter all prescriptions in PharmaNet, which promotes patient safety by providing information about all prescription medications dispensed to patients by community pharmacies in BC.
- PharmaNet prevents unintended duplication of prescriptions and prescription fraud, checks each prescription for drug interactions and allergies, and promotes cost-effective use of drugs.
- PharmaNet information is also utilized by regulators of health professions, health authorities and researchers as permitted under the Pharmaceutical Services Act and its regulations.
- PharmaNet is managed by the Ministry of Health and is maintained by the Ministry's contracted partner, MAXIMUS BC.

<u>Legislation</u>

- PharmaNet is governed by the *Pharmaceutical Services Act* and its regulations and complies with the BC *Freedom of Information and Protection of Privacy Act*. It includes privacy and security measures designed to prevent unauthorized access and protect the information in its databases.
- Patients can further limit access to their personal information by attaching a protective word to their file that would restrict access to their records unless the patient discloses the protective word to a health professional who is providing care to them. Hospital practitioners can request removal of the protective word if the patient requires urgent medical care and is unable to communicate the protective word, under the *Health Care (Consent) and Care Facility (Admission) Act*.
- The Information Management Regulation under the *Pharmaceutical Services Act* identifies who may access and record in PharmaNet. It permits the Minister of Health to set limits and conditions on user access to PharmaNet, and to suspend or terminate access if necessary.
- The Information Management Regulation also establishes a future requirement for all users to apply to the Minister for access to PharmaNet. The Ministry is engaged in the technical and process development required to implement this element of the regulation. Health Sector Information Management/Information Technology (IM/IT) Division's PharmaNet Revisions for Information Management Enhancements (PRIME) Project Fact Sheet has further details.
- The Ministry has received requests from other health practitioners who prescribe medications and who wish to access patient medication information recorded in PharmaNet. The associated health regulatory colleges are also seeking access to information to monitor their registrants.

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[1] PharmaNet Quarterly Statistics, HIBC, January 2021
[2] Pharmacy Type Report, HIBC January 2021
[3] HIBC Enrollment Services January 2021

- The Ministry recognizes the potential benefits and is currently assessing the technical and process changes required, along with the associated timeline, to provide access to several new practitioner groups and support better accountability for use of PharmaNet information.
- New user groups will be added to the regulation when operational capacity is in place.

Recent Projects

- The Pharmaceutical, Laboratory & Blood Services Division (PLBSD) is currently engaged with the Health Sector IM/IT Division and stakeholders to deliver electronic prescribing in BC. For details see the Electronic Prescribing Fact Sheet maintained by the Health Sector IM/IT Division.
- PLBSD has procured licensing for a software solution to process requests from prescribers, on behalf of patients, for covering non-regular benefit medications through the Special Authority program. The new application has been in use since April 2021.
- The Ministry is working with health authorities to support an electronic medication reconciliation process. This requires access to PharmaNet by hospital Clinical Information Systems. Island Health, Interior Health, and Vancouver Coastal Health Authority have rolled out this functionality.
- In collaboration with Provincial Health Services Authority, CareConnect, a clinical viewer, now includes access to PharmaNet. This integrated functionality was rolled out in Vancouver Coastal. We have begun the roll out of the viewer to community pharmacists in support of Covid -19 immunization.
- PLBSD is working with the ActionADE research team (University of BC / Vancouver Coastal Health Authority) to help prescribers and pharmacists avoid unintentionally re-exposing patients to harmful medications. Adverse Drug Events (ADEs) cause over 276,000 emergency department visits, 102,000 admissions and 1,982 deaths in BC annually.[4] A technical integration was completed and went live in December 2020 which permits the collection of enhanced ADE documentation from select acute care sites into PharmaNet and subsequent sharing of ADE information via PharmaNet to community pharmacies. The research team has begun a Randomized Controlled Trial in the spring of 2021 to assess the health outcomes derived from sharing this ADE information across care silo's. Ultimately, learnings from this research will inform the viability of future expansion and provincial roll out of ADE functionality.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**

June 3, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

June 7, 2021- Christine Voggenreiter obo ADM Martin Wright, Health Sector Information, Analysis and Reporting Division

[4] Hohl CM, Brubacher J, Hunte G, et al. Clinical Decision Rules to Improve the Detection of Adverse Drug Events in Emergency Department Patients. Academic Emergency Medicine 2012; 19(6): 640-9.

# LEGISLATIVE SESSION - FACT SHEET

# Point of Care Testing (POCT) – BC Policy

## TOPIC

Point-of-care Testing (POCT) is a form of patient centric healthcare, and refers to diagnostic tests performed at, or near, the site of a patient with the result leading to a possible change in care of the patient.[1] Technological advancements in POCT and increasing accessibility for citizens have resulted in a proliferation of POCT in community-based settings (e.g. community pharmacies, medical clinics, other).

## CURRENT SITUATION

- POCT is provided by healthcare professionals, other qualified healthcare providers, and in some cases by patients themselves. It can be performed in hospitals, clinics, laboratories, pharmacies, physician offices, ambulances, nursing and long-term care facilities, patient residences, or other community settings such as Urgent and Primary Care Centres.
- Typically, where POCT is not delivered in a laboratory, hospital, physician office or clinic, it is outside the scope of the College of Physician and Surgeons of BC (CPSBC) Diagnostic Accreditation Program (DAP). As a result, there may not be adequate oversight for test quality and patient safety.
- In response to the increased availability of POCT, the Ministry of Health has undertaken policy development to evaluate approaches that will continue to enable appropriate oversight for quality, safety, access and utilization of POCT in community-based settings.
- The Ministry developed a policy in collaboration with BC Health College Regulators, to provide guidance to the colleges in establishing community-based standards/guidelines for their regulated health professionals as per the *Health Professions Act*.
- The Ministry Community-Based Point-of-Care Testing Policy (May 1, 2020) includes best practices for:
    - Ensuring patient and provider safety
    - Testing locations and care environments
    - Patient referral and follow-up care for additional clinical/medical instruction and possible diagnostic confirmation
    - Developing proficiency and quality control for testing systems
    - Device and equipment safety considerations, and
    - Patient education
- The approved policy has been shared with BC Health College Regulators and is publicly available on the Ministry website.[2] Further consultation with the BC Health College Regulators is underway to enable implementation of this policy and encourage development of discipline-specific POCT Standards.

**POCT for COVID-19**

- In October 2020, the federal government began to approve COVID-19 POCT devices, and procured a large supply for provinces and territories to deploy. BC validated three devices for deployment within BC.
- On March 4, 2021, BC released the COVID-19 POCT strategy confirming POCT could be used in several settings including communities and settings where there are barriers to timely results through diagnostic PCR testing in symptomatic persons (rural, remote and indigenous communities, marginalized populations and remote worksites); and for asymptomatic persons in outbreak situations; in longterm care, assisted and independent living; correctional facilities; other congregate settings; and industries where outbreaks are more likely (e.g., food processing plants, onsite congregate living or camps).
- A Rapid POCT Team was established with representation from the Provincial Health Services Authority (PHSA), BC Centre for Disease Control (BCCDC) and COVID Response and Health Emergency Management Divison to support access to the federal stockpile of POCT, and ensure compliance with the Provincial Health Officer (PHO) direction for POCT.
- On March 16, 2021 the PHO published a letter confirming that any site, laboratory, or company that charges for COVID-19 POCT is required to receive full independent accreditation through the DAP. Any laboratory, or

[1] International Organization for Standardization (ISO) - ISO 22870:2016 – Point-of-care testing (POCT) – Requirements for quality and competence.
[2] https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/pharmacare/resources-related-to-drug-programs-and-policies-in-bc-and-canada/poct-policy

company that performs Health Canada approved rapid POCT for COVID-19 at no cost to the client being tested may instead follow the public health quality assurance process from the BCCDC.

- The March 16 letter further confirmed, under the *Public Health Act*, any positive test result must be reported to public health to enable public health follow up, including contact tracing and case management.
- The use of POCT devices employing Nasal Pharyngeal swabs is restricted to regulated health care professionals. The use of POCT devices using less invasive techniques (e.g., nasal swabs) is not restricted and can be performed by any individual who has been trained in the administration of the test.

**Self Administered POCT**

- Health Canada recently approved the first POCT self-test device for asymptomatic and symptomatic individuals (Lucira) and has procured 100,000 test kits for pilot projects. Health Canada has asked provinces to identify case uses and pilots and CRHEM is engaging public health partners on this.
- Lucira is single use, employs a nasal swab, and produces results in 30 minutes. The self-test kits will be available to Canadians through Amazon beginning in June, for a cost of $75/unit.
- The Testing and Screening Expert Advisory Panel that was established by Health Canada has begun exploration of self tests for its next report, expected in July.

## KEY FACTS

- Health Canada regulates the manufacturing and sale of medical devices, including POCT devices, via the *Food and Drugs Act* and the Medical Devices Regulations to ensure the safety of and efficacy of devices.
- In BC, the Ministry of Health regulates and influences the provision of POCT in specific medical/clinical domains (e.g., medical laboratories) using accreditation standards and scope of practice regulations. This includes:
    - The DAP evaluates and monitors performance standards in diagnostic healthcare, and administers accreditation programs for diagnostic services, including laboratory medicine. The scope of the DAP includes public and private diagnostic facilities within BC;
    - The DAP Non-Hospital Medical and Surgical Facilities Accreditation Program establishes accreditation and performance standards, procedures and guidelines for private facilities, and includes a standard for point-of-care testing which applies to: hemoglobin, blood glucose testing, urinalysis and pregnancy testing (urine), semen examination for the presence of sperm and occult blood (stool); and,
    - 15 simple point-of-care procedures that require minimal technology, training, and have a low rate of erroneous results that can be performed in physician's offices without requiring DAP accreditation[3].

## FINANCIAL IMPLICATIONS

As the number of POCT tests available increases, the Ministry and healthcare system will be required to assess the quality/safety of tests and the validity/reliability of test results. The health system may face increased pressure from patients to publicly fund new POCT tests. Some solutions have the potential to generate healthcare savings in the long term (e.g. tests that decrease adverse drug reactions or return rapid results to patients and avoid hospitalizations). To enable quality services for BC, the Ministry will need to routinely assess POCT devices for their potential cost and value to the health system.

**Approved:**
June 7, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 9, 2021 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division

[3] College of Physicians and Surgeons of British Columbia Position Statement – Point-of-care Diagnostic Tests Exempt from DAP Accreditation (2020, February 19).

# LEGISLATIVE SESSION - FACT SHEET

## Polypharmacy

### TOPIC

Polypharmacy is the use of multiple medications by an individual. It is a problem when the benefits of using multiple medications are outweighed by the negative effect of the sheer number of medications. It is more likely to occur in the elderly.

### CURRENT SITUATION

The Ministry of Health supports initiatives aimed at optimizing the use of drugs, including medication reviews, Call for Less Antipsychotics in Residential Care (*Clear),* the Doctors of BC's Share Care Polypharmacy Risk Reduction Initiative, Pharmacists in Primary Care Networks (PCN) program and others.

### KEY FACTS

- Polypharmacy, especially in older people, imposes a substantial burden of adverse drug events, non-adherence, ill health, disability, cognitive decline, fall, hospitalization, and even death.[1][2]
- Although a specific threshold for the number of medications to define polypharmacy has not been validated, it is known the risk of drug-related problems increases with the number of medications used.[3] Five or more medications are often a prompt for a medication review.
- In 2020, approximately 24.7% of BC residents age 70 and over were taking at least 5 medication per day, and 2.6% are taking 10 or more.[3]
- The Ministry supports activities aimed at optimizing the use of drugs. This includes healthcare professional education activities on polypharmacy provided by the Doctors of BC, the Therapeutics Initiative (TI) and *Clear* (also known as Call for Less Antipsychotics in Residential Care). The Ministry, through PharmaCare, also provides funding for pharmacists to conduct medication reviews.[4]
- The Doctors of BC's Shared Care Polypharmacy Risk Reduction Initiative was developed to reduce polypharmacy in the elderly by providing physicians with tools and strategies for deprescribing medications to improve patient safety and quality of life. It was implemented in three phases, focusing on prescribing in the following care settings:
  1) residential care (completed);
  2) acute care and transitions (completed); and
  3) community-based/primary care.

  Video series and bulletins were also developed to promote deprescribing in the elderly population.
- In September 2014, TI published its 90th Therapeutics Letter on "Reducing polypharmacy: A logical approach"[5] and described seven steps that health professionals, patients and their families can employ to become adept at de-prescribing. This work was funded by the Ministry through the TI contract.
- *Clear* was a clinical quality improvement initiative of the BC Patient Safety and Quality Council which supported long-term care homes to reduce the number of residents prescribed antipsychotic medications. Originally initiated in June 2013, the third wave of *Clear* began in December 2017 and concluded in May 2019. The final report is being finalized.
- In the first wave of *Clear*, participating care homes achieved a steady decline in antipsychotic use in from 38% to 32%. [6] In the second wave, a reduction was seen in the number of residents receiving antipsychotics, the number of prescriptions for antipsychotics and the doses of antipsychotics used.[6]

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[1] Lewis N. Too many drugs: solutions to polypharmacy problems. Med Economics Blog, Feb.10, 2017. www.medicaleconomics.com/medical-economics-blog/too-many-drugs-solutions-polypharmacy-problems

[2] Frank C, et al. Deprescribing for older adults. CMAJ 204; DOI:10.1503/cmaj.131873

[3] PharmaNet internal reporting (Therapeutic Initiative), Jan 6, 2021.

[4] (see "Pharmacy Medication Management Services" Fact Sheet).

[5] http://ti.ubc.ca/letter90

[6] A full report on the first wave of CleAR is available in The Journey Towards Dignity & Resident-Centered Care: Summary Results from the Call for Less Antipsychotics in Residential Care at https://bcpsqc.ca/wp-content/uploads/2018/03/CLeAR-Final-Report-sm.pdf.

- The third wave of *Clear* supported care homes that had an increased proportion of residents that received antipsychotics without a diagnosis of psychosis. It included 33 care homes that had 32.6% of their residents taking antipsychotics without a diagnosis, which was higher than the BC average of 25%.[7]
- PharmaCare Medication Review Services - PharmaCare reimburses pharmacists for conducting Medication Reviews, a one-on-one appointment between a patient and pharmacist where medication information is gathered, validated, summarized and reviewed. Patients who have taken at least five different medications in the previous six months and demonstrate a clinical need are eligible for the service. Medication reviews provide an opportunity to address polypharmacy through identification and resolution of drug related programs (refer to Fact Sheet on PharmaCare Medication Review Services).
- The Pharmacists in PCN program is supporting the addition of 50 clinical pharmacists into team-based primary care networks. 20 pharmacists will be integrated by September 2021 and another 30 will be added by September 2022. These pharmacists will provide comprehensive medication management service to patients with complex care needs by identifying and resolving drug therapy problems in collaboration with the patient and other members of the primary health care team. This will help reduce the risk of polypharmacy in a primary care setting.

## FINANCIAL IMPLICATIONS

N/A

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**Approved:**
February 6, 2020 - Brenda Rafter obo Philip Twyford, ADM, Finance and Corporate Services Division
January 29, 2021 - Mitch Moneo, ADM, Pharmaceutical Services Division
January 29, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division

[7] CLeAR Wave 2 Final Evaluation Report: https://bcpsqc.ca/resource/clear-wave-2-final-evaluation-report/

# LEGISLATIVE SESSION - FACT SHEET

## Pre-Exposure Prophylaxis of HIV

### TOPIC

- Pre-exposure prophylaxis (PrEP) refers to the use of ongoing (daily) oral antiretroviral therapy (ART) by people without HIV infection, both before and after possible HIV exposure, to reduce the risk of acquiring HIV infection.
- PrEP includes drug coverage of emtricitabine/tenofovir DF (FTC-TDF; Truvada® and generics) for PrEP of HIV.

### CURRENT SITUATION

- As of April 2021, more than 7,400 British Columbians have enrolled in the BC PrEP program since its introduction in January 2018, with participation by more than 1200 prescribers in BC[1]
- The BC-Centre for Excellence in HIV/AIDS (BC-CfE) continues to monitor the utilization and effectiveness of PrEP.
- Currently, PrEP is covered for eligible people in BC, Alberta, Saskatchewan, Ontario, Quebec, New Brunswick, Prince Edward Island, Nova Scotia, Newfoundland and Labrador, Northwest Territories, and Nunavut[2].

### KEY FACTS

- Effective January 1, 2018, British Columbians at high-risk are able to receive medication for PrEP of HIV to reduce the risk of acquiring HIV infection, at no cost. PrEP differs from HIV post-exposure prophylaxis where a short course of antiretroviral therapy (ART) is used following possible exposure.
- People at risk include men and transwomen who have sex with men, people who inject drugs, and people who have sex with individuals living with HIV. PrEP is part of a suite of tools to prevent new HIV infections, including use of condoms and sterile drug use equipment, and other risk reduction services and supports.
- The safety and effectiveness of FTC-TDF (Truvada® and generic brands, 1 tablet once daily) for PrEP has been established in a number of large international randomized controlled trials.[3,4,5,6]
- PrEP has been recommended as part of a combination HIV prevention package by the World Health Organization since September 2015.[7,8]
- In February 2016, Health Canada approved FTC-TDF for PrEP, to be used in combination with safer sex practices to reduce the risk of sexually acquired HIV in adults at high risk. The drug is also indicated in combination with other ART for the treatment of HIV infection in adults. It is the only drug currently approved for use in PrEP.
- In August 2016, the Canadian Agency for Drugs and Technologies in Health's Canadian Drug Expert Committee recommended that FTC-TDF be reimbursed for use as PrEP in combination with safer sex practices to reduce the risk of sexually acquired HIV-1 infection, provided that: 1) the drug is provided in the

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[1] Email, Mark Helberg, Senior Director, Internal and External Relations & Strategic Development, BC Centre for Excellence in HIV/AIDS. June 4, 2021.

[2] Immunodeficiency Clinic at Toronto General Hospital. Provincial/Territorial Coverage of ARV drugs for HIV prevention across Canada: Post-exposure prophylaxis (PEP) and Pre-exposure prophylaxis (PrEP). Retrieved January 23, 2020 from https://hivclinic.ca/wp-content/uploads/2019/07/ARV-Coverage_July-2019.pdf

[3] PROUD: McCormack, S. *et al.* (2015). Pre-exposure prophylaxis to prevent acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open label-randomised trial. The Lancet 387 (10013): 53-60. Retrieved 6 June 2016 from http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00056-2/abstract.

[4] Partners PrEP: Baeten JM et al. (2012) Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. The New England Journal of Medicine,367:399-410. Retrieved June 1, 2016 from http://www.nejm.org/doi/full/10.1056/NEJMoa1108524

[5] Bangkok Tenofovir Study: Choopanya et al. (2013) Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): a randomized, double-blind, placebo-controlled phase 3 trial. Lancet 2013,381:2083-2090. Retrieved June 1, 2016 from http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61127-7/abstract

[6] iPrEx: Grant, RM et al. (2010) Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men. N Engl J Med ; 363:2587-2599. Retrieved June 1, 2016 from http://www.nejm.org/doi/full/10.1056/NEJMoa1011205

[7] World Health Organization. (Nov 2015). Policy Brief: WHO expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP). Retrieved August 23, 2016, from: http://apps.who.int/iris/bitstream/10665/197906/1/WHO_HIV_2015.48_eng.pdf?ua=1

[8] World Health Organization (2012) Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects. In. Geneva, CH: World Health Organisation. Retrieved June 1, 2016, from: http://apps.who.int/iris/bitstream/10665/75188/1/9789241503884_eng.pdf

context of a sexual health program by a prescriber experienced in the treatment and prevention of HIV-1 infection, and 2) there is a reduced price.[9]

- On November 27, 2017, new Canadian guidelines recommended use of PrEP for men who have sex with men, transgender women, serodiscordant couples (i.e., couples where one person is living with HIV and the other is not), and people who share injection drug use equipment.[10]
- In November 2017, the BC-CfE updated the PrEP guideline, including clinical eligibility criteria, for the prevention of HIV acquisition in BC. This guideline is updated regularly, and the latest version was published August 2019.[11]
- Effective January 1, 2018, at-risk British Columbians are able to receive PrEP at no charge through the BC-CfE's HIV Drug Treatment program, which is funded by the Ministry of Health through the BC PharmaCare program.
- Details on the PrEP program and other related interventions for HIV are available on the BC-CfE website (www.cfenet.ubc.ca).
- While HIV/AIDS-related deaths in BC have decreased by more than 90% since 1996, new cases of HIV continue to emerge.[12] The rate of people diagnosed with new HIV infections has decreased 18% from 2015 to 2018 from a rate of 5.0 new diagnoses of HIV per 100,00 people in BC to 4.1 per 100,000 people.[13]
- PrEP is in addition to the made-in-BC strategy pioneered by the BC-CfE, known as Treatment as Prevention (TasP) that supports expanded reach of HIV treatment in order to reduce morbidity, mortality and HIV transmission. The TasP approach forms the basis of the provincial Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) program, funded by the Ministry through $19.9 million annually, and guided by the provincial HIV framework, *From Hope to Health: Towards an AIDS-free Generation*.

## FINANCIAL IMPLICATIONS

- The cost of funding PrEP did not require new funding because the savings from using the generic version of the drug supported the PrEP expansion within BC-CfE's current budget.
- The Ministry currently has a multi-year contract which has recently been extended to March 2022 (October 2018 - March 2022) with the BC-CfE through Providence Health Care for a total of $355 million over the term to manage and administer the BC HIV/AIDS Drug Treatment Program.. The contract is managed by the Pharmaceutical, Laboratory and Blood Services Division.

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**Approved:**

June 8, 2021 - Mitch Moneo, Pharmaceutical, Laboratory and Blood Services Division
June 10, 2021 – Christine Voggenreiter, obo Martin Wright, Health Sector Information, Analysis and Reporting Division
June 10, 2021 - Brenda Rafter, A/ED, obo Philip Twyford, ADM, Finance and Corporate Services Division

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[9] CADTH (2016) Canadian Drug Expert Committee Final Recommendation: Emtricitabine/tenofovir disoproxil fumarate (August 24, 2016). Retrieved October 6, 2017 from https://www.cadth.ca/sites/default/files/cdr/complete/SR0479_complete_Truvada_Aug-26-16.pdf

[10] Tan D et al. (2017 Nov 27) *Canadian guideline on HIV PrEP and nPEP.* CMAJ;189:E1448-58. Available at: http://www.cmaj.ca/content/189/47/E1448 Accessed October 5, 2018

[11] http://www.cfenet.ubc.ca/hiv-pre-exposure-prophylaxis-prep

[12] Eyawo, Oghenowede, Conrado Franco-Villalobos, Mark W. Hull, Adriana Nohpal, Hasina Samji, Paul Sereda, Viviane D. Lima, et al. "Changes in Mortality Rates and Causes of Death in a Population-Based Cohort of Persons Living with and without HIV from 1996 to 2012." BMC Infectious Diseases 17, no. 1 (December 2017). https://doi.org/10.1186/s12879-017-2254-7.

[13] BC Centre for Disease Control. (n.d.). Reportable Diseases Data Dashboard. Retrieved January 23, 2020 from http://www.bccdc.ca/health-professionals/data-reports/reportable-diseases-data-dashboard

# LEGISLATIVE SESSION - FACT SHEET

# Prescription Monitoring Program

## TOPIC

- Opioids, sedatives and stimulants are widely used for the treatment of many medical conditions including pain, insomnia and Attention Deficit Hyperactivity Disorder. Misuse of these medications, however, may be associated with serious adverse events and harms such as addiction, overdose and overdose death.
- Regular monitoring of the prescribing and dispensing of these medications and other problematic medications can reduce harm and improve patient safety.

## CURRENT SITUATION

BC currently has 3 separate programs monitoring the use of prescription opioids, sedative and stimulants:

PharmaNet

Links all BC community pharmacies to a central database and records the dispensing of all prescription drugs. This allows patient medication histories to be accessed in community pharmacies, physician offices, hospital emergency departments and health authority facilities. Physicians are expected as a College of Physicians and Surgeons of BC (CPSBC) clinical practice standard to review a patient's current medication history using PharmaNet before prescribing opioids, sedatives, or stimulants. PharmaNet access is mandatory at methadone clinics, urgent care clinics and multi-physician clinics. Community pharmacists are required by law (PODSA - 35(1) to review a patient's current medication history before dispensing any prescription medication. As part of the future BC Prescription Monitoring Program (PMP) it will be possible for all prescribers to have access to PharmaNet to provide a safer prescribing environment for all clinicians and patients.

CPSBC's Prescription Review Program

Uses a subset of PharmaNet data to review physician prescribing pattern of opioids, sedatives, and stimulants. Potentially inappropriate prescribing can be identified and addressed through further continuing education and specialized training. The other regulatory Colleges also oversee their registrant's activities but much of the work is incident based versus identified via regular monitoring.

PharmaCare's Restricted Claimant Program

Restricts the PharmaCare coverage of individuals who have been identified through routine screening or by a health care provider as having risky prescription medication use patterns to prescriptions written by a single prescriber and/or dispensed by a single pharmacy. As a separate initiative, this program is being modernized and is under review to ensure fairness with the process but also that it aligns with the focus of the BC PMP.

## KEY FACTS

- In January 2019, a service contract was signed between the Ministry of Health and the CPSBC to develop a proposal for implementation of an enhanced provincial Prescription Monitoring Program (BC PMP–Phase 1).
- The BC PMP aim is to use PharmaNet and other provincial data (e.g. MSP as applicable) to identify and prevent problematic prescribing and/or dispensing of medications, including but not limited to prescription opioids, sedatives and stimulants, allowing for more proactive interventions towards preventing harms associated with the misuse of prescription drugs.
- The 12-month contract allowed the CPSBC to lead and work with other professional regulatory colleges and other key stakeholders to set up a PMP Advisory Committee and to prepare a detailed proposal outlining the vision and implementation plan for the BC PMP.
- Ministry staff have worked with the BC PMP Project manager, CPSBC staff and the BC PMP Advisory Committee to outline the data, analytics and reporting framework that will support the work of the BC PMP, meet the individual health professional regulator needs, as well as develop and initiate a work plan of key activities for all functional aspects required to support and maintain the operations of the PMP.
- Members of the BC PMP Advisory Committee include the Ministry, the Ministry of Mental Health and Addictions, CPSBC, the College of Pharmacists of BC, the BC College of Nurses and Midwives, the College of Dental Surgeons of BC, , the College of Naturopathic Physicians of BC and the BC Coroners Service.

- Other health professional regulators, regional health authorities and First Nation Health Authority, BC Centre for Disease Control, and BC Centre for Substance Use may be included in the PMP Advisory Committee at a future date.
- The BC PMP Advisory Committee submitted their summary report, complete with budget projection, to the Ministry in January 2020. Due to COVID-19 emergent issues, the Ministry's review of the summary report proposal was delayed due to COVID and the Spring 2020 target for PMP implementation was not met.
- The BC PMP is a pivotal piece in the BC Government's response to the overdose crisis and this delay in approval of the project did not indicate a lack of support for the program.
- In December 2020 the BC PMP Advisory Committee submitted a proposal for preliminary work to begin on PMP operational development.
- Simultaneously the decision was made by the Ministry to proceed with the full proposal outlined in the Summary Report. As of February 10, 2021, preparations are underway to begin development of the full implementation contract for the BC PMP.

## FINANCIAL IMPLICATIONS

The Ministry had an initial 12-month contract (January 2019-January 2020) with the CPSBC for a total of $150,000 to create the infrastructure and initiate a preliminary work plan for the provincial PMP program. This contract was managed by the Pharmaceutical Laboratory and Blood Services Division.

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**Approved:**
January 27, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 12, 2021 - Peter Klotz obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

# Prosthetic and Orthotic Program

## TOPIC

Coverage for BC residents through the Prosthetic and Orthotic Program is funded by the Pharmaceutical, Laboratory, and Blood Services Division through various PharmaCare plans.

## CURRENT SITUATION

- PharmaCare is responsible for assisting eligible patients in paying the cost of eligible prostheses and orthoses, subject to the patient's usual plan rules, including any deductible and family maximum amounts.
- BC is the only province in Canada to link drug program deductibles to coverage of prostheses and orthoses. Most other provinces have separate programs operating within their respective health ministries.
- PharmaCare is currently evaluating the reimbursement amounts paid to device providers dispensing prostheses and orthoses on behalf of patients.
- Effective October 1, 2019, prosthetic osseointegration (OI) benefits are available to any Trans-Femoral (TF) (above the knee) amputee who has undergone OI implant surgery. Effective June 1, 2021, prosthetic osseointegration (OI) benefits are also available to any Trans Tibial (TT) (below knee) amputee who has undergone OI implant surgery.

## KEY FACTS

- Pursuant to the Provider Regulation under the *Pharmaceutical Services Act*, device providers require pre-approval of proposed work, with a only a few exceptions such as supplies and repairs under $400 and, effective August 1, 2020, hip abduction orthoses; and replacement ocular, nose and ear prostheses that meet eligibility criteria. To receive pre-approval, a device provider submits an Application for Financial Assistance form on behalf of their patient.
- Price is considered in each application.
- PharmaCare provides 100% reimbursement for eligible prostheses and orthoses for individuals under Plan B (Residential Care Facilities) (prostheses only), Plan C (Income Assistance) and Plan F (Children in the At Home Program).
- For individuals covered under the Fair PharmaCare plan, the usual deductible and co-payment rules apply and all drug and non-drug benefits are aggregated in paying deductibles and annual maximums.

**Prostheses**

- Reimbursement for prostheses is limited to basic functionality and does not include back-up prosthetic limbs or accessories.
- PharmaCare contracts with a prosthetist to adjudicate all prosthetic claims requiring pre-approval.

**Osseointegration**

- OI benefits include coverage of a microprocessor knee, which is not a benefit for other TF (above the knee) amputees, due to the increased risk of catastrophic damage to the implant if the patient should fall.
- The OI schedule published by PharmaCare is an example of the level of funding and is not a comprehensive list of all components that are covered.
- In 2016, the Medical Services Plan paid for 3 TF amputees to receive OI surgery in Australia; PharmaCare received several requests afterwards to fund prostheses for these patients.
- OI benefits are now available for TT (below the knee) amputees and include the same components except the microprocessor knee which is not required for this patient group..

**Orthoses**

- Reimbursement for children and youth age 18 and younger for orthoses is limited to devices required to achieve or regain basic functionality or for the prevention of further deformity, including permanent lower extremity orthoses (covering at least the ankle), and spinal orthoses needed to correct spina bifida, scoliosis and similar medical conditions.

- PharmaCare also provides reimbursement for plagiocephaly helmets for children under the age of 2.
- Orthoses have a maximum reimbursement amount based on the type of orthosis.
- Orthoses required post-surgically, or as a result of injury, are not benefits for individuals of any age; orthoses for adults are not covered as benefits.

**Provider Fees**

- On December 14, 2010, PharmaCare increased reimbursement rates for prostheses and orthoses to offset inflationary pressures that had not been addressed for several years. Specific changes included increasing the fee provided for the fabrication of a prosthetic socket and establishing a defined fee schedule for orthoses.
- The 2010 socket fee increases raised PharmaCare's reimbursement rates to the amounts requested by the Prosthetic and Orthotic Association of BC in 2004, which were still 5% lower than the Association's 2008 socket fees request. The Association subsequently presented the Ministry with new 2014, 2016, 2018 and 2020 fee guideline prices for both prosthetic and orthotic devices, but financial constraints have prevented the Ministry from moving forward with any additional increases.
- Most device providers are charging patients more than PharmaCare's reimbursement rates. This results in increased out-of-pocket costs for patients and creates financial hardship for patients on PharmaCare plans that cover 100% of the eligible reimbursement rate but leave the patient responsible for the difference in cost.
- PharmaCare is currently evaluating the reimbursement amounts paid to device providers dispensing prostheses and orthoses on behalf of patients.

## FINANCIAL IMPLICATIONS

The following is a table[1] outlining the total cost and number of claims for prostheses, orthoses and associated eligible supplies for 2019/20:

| Medical Device Expenditure ($ Million) | | No. of Claims |
|---|---|---|
| Prostheses | $8.84 | 4,736 |
| Orthoses | $1.67 | 1,107 |
| **Total** | **$10.51** | **5,843** |

**Approved:**

January 28, 2021 – C. Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 12, 2021 – Peter Klotz, obo Philip Twyford, ADM, Finance and Corporate Services Division
May 31, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

[1] PharmaNet, Health Sector Information, Analysis and Reporting Division, January 28, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Provider Enrolment and Pharmacy Incentives

### TOPIC

- Pursuant to the *Pharmaceutical Services Act* (the Act) a pharmacy or device provider must be enrolled in the PharmaCare program in order to submit claims to PharmaCare on behalf of PharmaCare beneficiaries.
- All BC pharmacies and device suppliers that are enrolled as a PharmaCare provider are prohibited from offering incentives related to pharmaceuticals and/or medical supplies to their customers in an attempt to attract or retain business.

### CURRENT SITUATION

- The goal of the Provider Regulation (the Regulation) under the Act is to protect the financial integrity of the PharmaCare program by ensuring there is a transparent and consistent means by which provider eligibility for enrolment may be assessed.
- Under the Act, offering incentives to patients to frequent a particular provider is an offence; the College of Pharmacists' (the College) bylaws also prohibit the provision of incentives.
- Two pharmacies that were denied enrolment in the PharmaCare program in 2015 once the Provider Regulation came into force (Eastside Pharmacy ([Eastside] and Community Outreach Pharmacy [Community]) applied for judicial review of the decisions to deny enrolment. Community subsequently changed their operating name to Global Outreach Pharmacy (Global Outreach).Government Financial Information

Government Financial Information

Government Financial Information Mediation occurred in the case of Global Outreach and they are no longer challenging their denial of enrolment in PharmaCare. Global Outreach has closed effective December 25, 2020.

### KEY FACTS

- The Act's Provider Regulation came into force on December 1, 2014.
- As of June 1, 2015, all pharmacies and device providers intending to submit claims to PharmaCare were required to enrol as a provider under the terms of the Regulation.
- The intent of the Regulation is not to be punitive or to limit the number of providers in BC, but to give the Province a means to exercise discretion before entering into a business relationship that may not be in the public interest.
- The Regulation prescribes the criteria a pharmacy or device provider must meet to be enrolled as a provider. The prescribed criteria state that a pharmacy or device provider is ineligible for enrolment if an owner or manager has:
    - an outstanding audit amount owing to a public insurer;
    - a conviction, an order, or is under prosecution for an information or billing contravention;
    - billing privileges cancelled, or currently suspended at another site;
    - convictions for fraud under the *Criminal Code*, drug trafficking or offences under the *Controlled Drugs and Substances Act* within the previous 6 years;
    - a judgement entered against him or her in the previous 6 years regarding business activities related to the site or the provision of benefits; and
    - had his or her registration with a regulatory body cancelled or suspended.
- If satisfied the applicant meets the prescribed criteria, the Minister may enrol the applicant, unless the Minister is of the opinion it would not be in the public interest to do so. The Minister has delegated the authority to make decisions regarding Provider Enrolment to the ADM of the Pharmaceutical, Laboratory, and Blood Services Division (PLBSD) and the ADM of Finance and Corporate Services.
- In 2015, the Ministry reviewed almost 1,300 applications for enrolment under the Regulation. As a result of the review, 47 applications were brought to the attention of the ADM at PLBSD, who had been delegated through a Ministerial Order the authority to refuse enrolment.
- The Ministry sent notice letters to all 47 pharmacies advising the pharmacy owners of its intent to deny enrolment. The Regulation allows the applicant 21 days to respond, in writing. After considering the responses,

the PLBSD's ADM either confirmed or reversed the decision to deny enrolment of each pharmacy; the applicants were provided with written notice of these decisions.

- Eastside and Global Outreach applied for judicial review of the decisions to deny enrolment. Security Concern Security Concern and Global Outreach secured temporary stays and temporary enrolment in the PharmaCare program pending the hearing of the merits of the judicial reviews. The Court ordered in both cases that the Minister produce documents as part of the administrative "record". In both cases the Minister applied for leave to appeal the order, Security Concern Security . Mediation occurred in the case of Global Outreach and they are no longer challenging their denial of enrolment in PharmaCare. Global Outreach has closed effective December 25, 2020. The case of Security Concern

- A pharmacy refused enrolment in the PharmaCare program is not authorized to submit claims on behalf of PharmaCare beneficiaries for reimbursement. The pharmacy is still permitted to dispense medications to cash payers or for reimbursement via private insurers, though in cases where PharmaCare enrolment has been terminated the pharmacies involved have usually ceased operations.
- PharmaCare clients that previously filled prescriptions at pharmacies that have subsequently been denied enrolment are not able to use these pharmacies to fill PharmaCare-covered prescriptions. Instead, they have to find new pharmacies which are enrolled with PharmaCare or pay for the prescriptions out of pocket.
- PharmaCare beneficiaries can choose which enrolled pharmacy they want to use to fill their prescriptions. The Ministry publishes a list of pharmacies on its website to inform PharmaCare beneficiaries which pharmacies are not enrolled in the PharmaCare Program due to their applications being denied or their enrolments cancelled, and which providers are enrolled with limits and conditions. This list is regularly updated.[1]
- When a pharmacy's enrolment is revoked, or certain limits and conditions applied, the Ministry works with a host of regulatory bodies, associations and agencies to ensure patients have a seamless move to a new pharmacy nearby.

Incentives

- Pursuant to Section 51(2) of the Act, a person commits an offence if they offer an incentive to any person as an inducement to refer a PharmaCare beneficiary for the purposes of that beneficiary receiving a benefit from a particular pharmacy provider. The Act defines "incentive" as "money, gifts, discounts, rebates, refunds, customer loyalty schemes, coupons, goods, rewards and other prescribed things".
- The College regulates pharmacy practice in the province. In January 2016, College bylaws prohibiting pharmacies from providing incentives (or inducements) came into effect. The bylaws are not limited to incentives provided to PharmaCare beneficiaries.
- According to the College, incentives can inappropriately encourage drug use which puts patients' health at risk and can disrupt continuity of care as a patient may switch pharmacies for the best incentive.

## FINANCIAL IMPLICATIONS

The Ministry has retained legal counsel from the Ministry of Attorney General to act in its interest throughout the process to deny enrolment, and judicial review proceedings that may be instituted.

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**Approved:**
June 1, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory, and Blood Services Division

[1] Available at: https://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/not-enrolled-or-enrolled-with-conditions#deniedandcancelled

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Health Services Authority: Laboratory Services

### TOPIC

- The Provincial Laboratory Medicine Services (PLMS) formerly BC Agency for Pathology and Laboratory Medicine is a program within the Provincial Health Services Authority (PHSA).
- PHSA is tasked with providing administrative oversight of the delivery of publicly funded laboratory services across BC and developing a service delivery model for integrated planning and service coordination for the public and private laboratory system.

### CURRENT SITUATION

- Enacted in 2015, the *Laboratory Services Act* (LSA) resulted in a single governance structure for laboratory services to enable the rationalization and integration of laboratory services, realization of the benefits of emerging technologies, enhanced quality and system sustainability. It also enabled the Ministry to enter into agreements with providers, allowing for greater certainty in the provision of laboratory services, including quality and expenditures, and to assign certain LSA administrative functions to organisations such as the PHSA.
- Inpatient laboratory testing is provided through health authority laboratories and funded through global operating budgets.
- Outpatient / community laboratory testing is provided in public laboratory facilities operated by BC health authorities, and through two private laboratory providers, Valley Medical Laboratories (VML) and LifeLabs (which provides about 2/3 of outpatient testing in BC).
- Under the LSA, there are 108 public and private laboratories approved to bill the Medical Services Plan for outpatient laboratory testing. The approved laboratories are supported by a network of 189 specimen collection sites, of which 53 are publicly-owned and 136 are privately-owned.[1] In 2019, there were approximately 295 laboratory medicine physicians (pathologists) in BC.[2]
- Funding for outpatient testing is via fee-for-service; however, a modified fixed fee funding model exists for LifeLabs, and a hybrid model with a mix of fixed fees and fee-for-service payments exists for VML through their contracts with the Ministry.
- The Alliance Management Office of the PHSA is responsible for day-to-day administration, monitoring and management of the VML and LifeLabs service agreements on behalf of the Ministry.

### KEY FACTS

- In Spring 2018, the Agency (previously under the BC Clinical and Support Services Society) became part of PHSA. The intent was to support a more streamlined system, more effective oversight, better services for British Columbians, and cost savings to the health system.
- In June 2018, the Agency assumed day-to-day administration of the Out of Country / Out of Province program for the Ministry; and as of April 1, 2019, the Agency assumed accountability for eight more administrative functions.[3]
- As of January 2020, PHSA consolidated the Agency, Provincial Blood Coordinating Office and Lower Mainland Laboratories into a new division: the Provincial Laboratory Medicine Services. PHSA also engaged in a restructuring of the governance model to achieve a more streamlined and efficient organization, with some committees combined, restructured or discontinued. This work has been put on hold during the COVID-19 pandemic.
- The PHSA's 2019/20 mandate letter[4] directed PHSA to begin integrated planning, coordination and consolidation of pathology and laboratory medicine services under a single operating model, with an

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[1] Email, Confirmed by Provincial Laboratory Medicine Services, September 14, 2020.
[2] Scott's Medical Database, Canadian Institute for Health Information, Supply Distribution and Migration of Canadian Physicians, https://secure.cihi.ca/estore/productSeries.htm?pc=PCC34 Accessed February 16 ,2021
[3] CLIFF 1122323 Roy Transfer of Lab Service Functions, September 28, 2018
[4] CLIFF 1129703 Provincial Health Services Authority 2019/20 Mandate letter, signed March 26, 2019

emphasis on how to position these over the next five to ten years in the context of rapidly evolving technologies. PHSA, through the Agency, was directed to:
  - Continue with province-wide oversight of delivery of publicly funded laboratory services.
  - Accept accountability for the eight functions assigned by the Ministry to support the LSA.[5]
  - Make recommendations to the Ministry on genomic and genetic testing and related services, using the genomic and genetic strategic framework approved by the Ministry.
  - Improve efficiency and effectiveness of priority clinical laboratory and pathology service delivery areas (including genomic and genetic testing) critical to quality and sustainability.
- In October 2019, PHSA provided the Ministry a letter of commitment outlining a clinical value proposition and service delivery model for integrated planning and service coordination for the public and private laboratory system, including responsibility for overall budget management and key performance indicators on regulatory function, policy and engagement, and clinical service delivery.
- In late November 2019, PHSA received support from Leadership Council to implement a high-level plan focused on integration initiatives (e.g. service consolidation to high-volume locations; expansion of point-of-care testing); demonstrating the clinical value proposition (e.g. through new clinical policy for routine inpatient bloodwork testing; standard operating procedures; realignment of cytogenetics services; coordination of maintenance service contracts); and, to collaborate with the Regional Health Authorities on coordinating laboratory physician contract management, laboratory accreditation efforts and provincial workforce strategy for laboratory medicine.
- The PHSA's 2020/21 mandate letter speaks to this collaboration with RHAs, as PLMS implement the Ministry of Health's approved 3-year plan (2020/21 – 2022/23) for pathology and laboratory medicine including overall budget oversight.
- In early 2020, as part of the province's COVID-19 response, PHSA/PLMS formed the Provincial Laboratory Emergency Operations Committee (EOC) to strategize and coordinate a provincial response, under the leadership of PLMS and comprised of laboratory medical and operations leaders from all health organizations, private laboratory providers, First Nations Health Authority and the Ministry; in addition, PLMS led and coordinated across all health organizations and health system partners to establish COVID-19 surge capacity – achieving a capacity of 20,000 tests per day target by the late Fall 2020.

## FINANCIAL IMPLICATIONS

In 2019/20, government spent approximately $492 million for in-patient and health authority funded testing, approximately $360.8 million[6] on out-patient fee-for-service laboratory testing,[7] and $3.9 million on out-of-province / out-of-country laboratory testing. [8]

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**Approved:**
February 1, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory & Blood Services Division
February 15, 2021– Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
February 19, 2021 – Eric Larson obo Martin Wright, ADM Health Sector Information, Analysis & Reporting Division

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[5] Until such time as the Minister of Health delegates authority under the LSA, the PHSA is required to forward recommendations to the Ministry for review and approval, then implement Ministry-approved direction.
[6] Health Sector Information, Analysis and Reporting Division, Integrated Analytics: Primary Care, Acute Care and Workforce Branch, Fiscal Year 2020/2021 Q2 Report on Out-patient Fee-For-Service Laboratory Services Claims Volume and Expenditure. Feb. 2020.
[7] Health Sector Information, Analysis and Reporting Division, it includes: Lifelabs, VML, Health Authorities, and other providers.
[8] Per PHSA monthly invoices.

# LEGISLATIVE SESSION - FACT SHEET

## Provincial Retinal Diseases Treatment Program

### TOPIC

- BC's Provincial Retinal Diseases Treatment Program provides coverage of several drugs that prevent blindness and improve vision for 21,857 British Columbians in 2019/20. Compared to other provincial jurisdictions, the approach used in BC is extremely cost-effective and very comprehensive.
- While very successful, concerns with the Program were raised due to the Program's inclusion of bevacizumab for an "off-label" use and restricting the funding of treatments provided to participating retinal specialists. In 2018/19, there were concerns raised around the risk of glaucoma in a small portion of patients receiving treatments through the Program. The three drugs used in the Program (see below) were previously known to increase the risk of glaucoma.
- The Ministry with Provincial Health Services Authority (PHSA) have implemented risk mitigation strategies and investigations are ongoing to understand the concern.

### CURRENT SITUATION

- In May 2019, the Ministry and PHSA issued a News Release to inform patients of the possible risk for glaucoma surgery following treatments offered by the Program based on a recommendation by all 29 retinal specialists in the Program, as well as two glaucoma specialists. The concern related to potentially increased rates of patients needing glaucoma surgery (i.e. up to 2.1% over two years of therapy) following intravitreal injections. The specialists recommended against suspending the Program as this would result in greater risk for patients of deterioration of vision and vision loss if treatments were not covered for patients with high unmet need.
- In mid-July 2019, a subset of Program retinal specialists, who were experiencing high variability related to glaucoma surgery, began using Norm-Ject syringes. The BD insulin syringe remains the predominant syringe used in the Program and is also used in other Canadian jurisdictions.
- The Program's unique retinal database provides the ability to undertake quality reviews including studying, examining and linking to other Ministry databases to optimize patient care and reduce avoidable risks and harms to patients. Three quality reviews have been completed to date. The objective of this review is to examine the relationship between glaucoma incidence and anti-vascular endothelial growth factor (anti-VEGF) treatments. A Quality Review Working Group, which includes researchers, retinal and glaucoma specialists and consultation with experts within and outside of BC, is directing this work. The COVID-19 pandemic has delayed the release of Quality Review Phase IV. More information on the quality review is available at:http://www.phsa.ca/our-services/programs-services/provincial-retinal-disease-treatment#Quality--Improvement

### KEY FACTS

- The Program, initiated in 2009, provides 100% coverage for bevacizumab (Avastin), ranibizumab (Lucentis) and aflibercept (Eylea) for the treatment of three retinal diseases, namely wet Age-related Macular Degeneration (wAMD), Diabetic Macular Edema (DME) and Retinal Vein Occlusion (RVO). The Program also covers verteporfin (Visudyne) with Photodynamic Therapy for wAMD. Drug therapy for other retinal diseases are not covered.
- Vials of retinal drugs contain enough drug to safely prepare multiple individual doses from one vial.
- The PHSA continues to manage the Program and drug coverage is not subject to Fair PharmaCare deductibles or co-payments. The Program provides coverage when the drugs are prescribed and administered by retinal specialists who have signed agreements with PHSA to participate in the Program and submit data into a provincial database.[1]
- In October 2014, a review found 96% of all retinal drug treatments in BC were provided through the Program retinal specialists, suggesting the Program provides excellent public coverage overall. By

[1] Retinal specialists are ophthalmologists with additional education specializing in retinal disease and are available in all regional health authorities. They provide clinical expertise and expertise with retinal angiography to diagnose and monitor wet AMD, DME and RVO. Health providers and optometrists can refer new patients directly to retinal specialists for diagnosis and treatment.

comparison, PharmaCare pays for about 35% of total drug expenditures in BC, whilst the remainder is funded privately. The Program continues to monitor access and conduct assessments with health authorities/retinal specialists, and adjustments will be made as required.

- The Program monitors drug safety and effectiveness of retinal treatment drugs, since all participating retinal specialists track the safety and effectiveness of each treatment dose that is administered.
- When the program was started in 2009, concerns were raised by Novartis, the manufacturer of ranibizumab, and some patient groups for covering bevacizumab, as it is marketed for treatment of several cancers but prescribed off-label nationally and internationally to treat AMD, DME and RVO. Ranibizumab is 135 times more expensive than bevacizumab. Clinical evidence supports the use of bevacizumab. Research into the efficacy and safety of bevacizumab compared to ranibizumab for wet AMD come from the IVAN (2-year results) study published in July 2013.[2] This study concluded vision improvement is the same for bevacizumab as it is for ranibizumab and there is no increased safety risk with bevacizumab. The IVAN study reinforces the similar efficacy results observed in a direct comparison of the 2 drugs published in the CATT trial.[3] A recent real-world safety study conducted using BC Program patient data concluded that single or repeated doses of intravitreal bevacizumab were not shown to increase the risk of myocardial infarction or stroke in patients with wAMD.[4]
- All jurisdictional drug plans currently cover ranibizumab. BC, Alberta, Manitoba, New Brunswick, Nova Scotia, Yukon and Veterans Affairs also currently cover bevacizumab. Alberta's retinal disease program is similar to BC and includes bevacizumab and restricting treatments to retinal specialists.
- In May 2016, the Canadian Agency for Drugs and Technologies in Health (CADTH) completed a therapeutic review of bevacizumab, aflibercept and ranibizumab. The review recommends bevacizumab as the preferred initial therapy and ranibizumab and aflibercept as alternative options in patients who do not respond or are intolerant to bevacizumab. This supports BC's approach.
- In January 2015, University of BC (UBC), PHSA, and Program retinal specialists agreed to fund a UBC-based research/evaluation unit to support the decision makers and clinicians. The 5-year funding contribution from PHSA ended in 2018/19. The Program continues to review all aspects of care under the program, from the pharmacy to the retinal specialist office, and will continue to implement quality improvements to the program.

## FINANCIAL IMPLICATIONS

- The Program is very successful, treating 21,857 patients in 2019/20 for $22.97 million[5].
- BC's approach to retinal drugs coverage was unique in Canada when first introduced. Other provinces (Alberta) have since adopted the same approach. If BC had followed other provinces that provide coverage for ranibizumab only without preparation of multiple doses from 1 vial and without using bevacizumab, the Program would cost more than $83 million per year for wAMD or more than $156 million for 3 indications.

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**Approved:**

January 25, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 12, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM Finance and Corporate Services Division

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[2] IVAN Study Investigators. Alternative treatments to inhibit VEGF in age-related choroidal neovascularisation: two-year findings of the IVAN randomisation-controlled trial. www.thelancet.com published July 19, 2013 (http://dx.doi.org/10.1016/S0140-6736(13)61501-9 )

[3] CATT trial. Ranibizumab and bevacizumab for treatment of neovascular age-related macular degeneration: two-year results. www.aaojournal.com published online May 2, 2012 (doi:10.1016/j.ophtha.2012.03.053)

[4] Etminan M. et al. Risk of Myocardial Infarction & Stroke with Single or Repeated Doses of Intravitreal Bevacizumab in Age-Related Macular Degeneration. Am J Ophthalmol.2015 Dec 14. pii:S0002-9394(15)30005-2 (doi:10.1016/j.ajo.2015.11.030.) http://www.ncbi.nlm.nih.gov/pubmed/26701272

[5] PHSA utilization review (2019/20) of the program patient and treatment database managed by PHSA

# LEGISLATIVE SESSION - FACT SHEET

## Reference Drug Program

### TOPIC

- Under the Reference Drug Program (RDP), drugs that treat the same disease are grouped together into therapeutic categories called RDP categories. The drugs in an RDP category may have different active chemical ingredients but have the same clinical benefit(s) and risks and may differ in cost.
- The Ministry of Health 2014/15-2016/17 Service Plan outlined the strategic priorities including ensuring value for money and evidence informed access to clinically-effective and cost-effective pharmaceuticals, as well as leveraging programs such as Low Cost Alternative and RDP to achieve the best therapeutic value and price for publicly-funded pharmaceuticals.

### CURRENT SITUATION

- Modernizaton of the RDP began in 2016, with the introduction of three new RDP categories and modification of three existing RDP categories.
- A second phase of RDP modernization, updated two of the original RDP categories, the non-steroidal anti-inflammatory and oral nitrates categories, effective April 1, 2021:
    - The nitrates group was removed. All nitrates are now regular PharmaCare benefits.
    - In the nonsteroidal anti-inflammatory drugs (NSAIDs) category, the list of fully covered and partially covered drugs is changed. However, patients will not lose their current coverage for any drugs removed from the NSAIDs group.
    - The following NSAID drugs became Limited Coverage drugs, but current users will continue to have coverage: diclofenac with misoprostol, diflunisal, flurbiprofen, indomethacin, ketoprofen regular and sustained release.
    - Ibuprofen 200 mg is no longer covered for most PharmaCare plans; however, coverage of this medication will be continued for patients who are current users and registered under Plan B and Plan W. All patients with current full and partial benefit coverage for a non-reference product within 6 months prior to the Phase 2 changes effective April 1, 2021, were provided with legacy full coverage.
- Patients on a non-reference drug(s) are only provided partial coverage. In order to obtain full coverage, patients either switch to a safe and efficacious fully-covered drug or pay the difference out of pocket.
- Modernization has resulted in some savings to the PharmaCare Program which allows the program the ability to pay for formulary expansion with other drugs.

### KEY FACTS

- In the 20+ years since the launch of the RDP, drug prices have decreased with the introduction of more generic products. In July 2012, the Provincial/Territorial Premiers provided the Health Care Innovation Working Group of the Council of the Federation with direction to achieve better prices for generic drugs. This ongoing work is resulting in lower price points for common generic drugs (i.e. 10% of brand pricing) which support RDP modernization.
- The RDP is founded on Drug Benefit Council (DBC) recommendations and input from clinician experts. The DBC reviewed RDP policy, systematic reviews, an environmental scan, clinical evidence of various therapeutic classes, utilization, budget impact assessments, and clinical practice reviews for Phase 1: at the May 5, 2014, September 15, 2014 meetings and approved Phase 2 changes on May 6, 2019.
- RDP Modernization Phase 1 (complete):

  Three new therapeutic categories launched:
    - Angiotensin Receptor Blocker (ARB) – treats high blood pressure; alternative to angiotensin-converting-enzyme inhibitor (ACEI);
    - Statin – treats high cholesterol; and
    - Proton Pump Inhibitor (PPI) – treats gastrointestinal issues (i.e. reflux); alternative to H2 Blocker.

  Modification of three existing therapeutic categories:
    - ACEI – treats high blood pressure;

  - Calcium Channel Blocker (CCB) – treats high blood pressure; and
  - Histamine 2 (H2) Receptor Blocker – treats gastrointestinal issues, including reflux.
- RDP Modernization Phase 2 (complete):
  Modification of two existing therapeutic categories:
  - Oral long acting nitrates – treat cardiovascular conditions, e.g. angina;
  - Non-steroidal anti-inflammatories (NSAIDs) – treat inflammatory conditions e.g. rheumatoid arthritis and musculoskeletal conditions e.g. osteoarthritis.
- The RDP in 2021 consists of 7 category groups: ACEI, ARB, CCB, H2Blockers, NSAIDs, PPIs, and Statins .

Background

- The RDP program, introduced in 1995, is a PharmaCare policy to encourage cost-effective prescribing for common medical conditions.
- Under the RDP, drugs that treat the same disease are grouped together into therapeutic categories called RDP categories. The drugs in an RDP category may have different active chemical ingredients but have the same clinical benefit(s) and risks and may differ in cost.
- Clinical safety and effectiveness evidence support the therapeutic class pricing concept of the RDP, with ongoing support that therapeutic class pricing is a viable policy approach to achieve savings without negative clinical impacts. There is also support from the long-standing hospital therapeutic interchange policies that are based on the same premise in place for decades.
- Drugs in each RDP category are either reimbursed fully (reference drugs) or partially (non-reference drugs) based on cost effectiveness.
- Each RDP category has one or more drugs considered as reference drugs which are reimbursed fully according to the manufacturer's list price plus markup subject to a patient's usual plan rules and deductibles. Among the reference drugs, one drug in each RDP category is designated the reference drug comparator. The non-reference drugs in each RDP category are partially covered up to the reference drug comparator price. For the drugs that are partially covered, the balance of the cost is the patient's responsibility.
- If a patient has a specific medical condition that prevents him/her from taking any of the reference products in an RDP category (e.g. a drug-to-drug interaction, drug intolerance, or a previous treatment failure), a practitioner may apply for Special Authority consideration for full coverage of one of the non-reference drugs in the RDP category.
- Previously, there were five RDP categories introduced in 1995 and 1997: (1) nonsteroidal anti-inflammatory drugs (in 2010, the reference drug comparator was changed from naproxen to ibuprofen); (2) H2 Blockers; (3) nitrates; (4) ACEIs; and (5) dihydropyridine CCBs.

## FINANCIAL IMPLICATIONS

The PharmaCare expenditure on RDP drugs decreased by $12.4 million and $19.2 million respectively in the first year and second year after launching Phase 1 of the modernization of the RDP program. This decrease can be mostly attributed to the RDP modernization .[1]

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**Approved:**

June 3, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 7, 2021- Christine Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
June 8, 2021 - Brenda Rafter, obo Philip Twyford, ADM, Finance and Corporate Services Division

1 PharmaNet, Health Sector Information Analysis and Reporting Division, February 27, 2019.

# LEGISLATIVE SESSION - FACT SHEET

## Smoking Cessation Program

### TOPIC

BC Smoking Cessation Program helps BC residents stop smoking by providing coverage of prescription drugs or nicotine replacement therapies (NRT).

### CURRENT SITUATION

- The Program covers NRT products through contractual agreements from a competitive bidding process.
- Following a Request for Proposal (RFP) process through BC Bid, a new contractual agreement with the winning proponent was implemented on January 1, 2021 for continued coverage of NRT products.
- The Ministry of Health completed an impact evaluation of the Program in 2020 and published the Report on the BC Smoking Cessation Program Evaluation Survey in January 2021.[1]

### KEY FACTS

- According to Statistics Canada, BC continues to have the lowest smoking rate in Canada at 11.1% in 2019, which is a decrease by 0.9% compared to 2018. The national smoking rate was 14.8% in 2019. In contrast, Newfoundland and Labrador was at 19.5% in 2019 and Nova Scotia was at 18.3% in 2019.[2]
- In 2014, Drug Safety and Effectiveness Network's (DSEN) evaluation concluded the following: 1) continued abstinence rates (CAR) at 12 months are better for bupropion, varenicline, nicotine gum, compared to placebo; 2) CAR at 12 months are better for bupropion, varenicline, nicotine gum, nicotine patch plus an active behaviour support program compared to an active behaviour support program on its own; and 3) no safety signal for cardiovascular events or suicides was identified, however, results should be interpreted with caution given the small number of trials reporting these outcomes and the low number of events available for analysis. The DSEN report was made publicly available by the researchers in December 2014.[3]
- The Ministry's BC Smoking Cessation Program, launched September 30, 2011, helps BC residents stop smoking by providing the choice of either a no-cost supply of either nicotine replacement therapy, or PharmaCare coverage of prescription drugs bupropion (Zyban®), or varenicline, for up to 12 weeks. Non-prescription smoking cessation products are NRTs, and include nicotine gum, transdermal patches, and lozenges.
- Following the completion of the first competitive tender, between September 30, 2011, and December 31, 2015, the Program provided coverage for 1 brand of nicotine gum (Thrive™) and 1 brand of nicotine patches (Habitrol®).
- Following the completion of the second competitive tender, between January 1, 2016 and December 31, 2020, the Program provided coverage for 1 brand of nicotine gum (Nicorette®), 1 brand of nicotine patches (Nicoderm®), 1 brand of nicotine lozenge (Nicorette®), and 1 brand of nicotine inhaler (Nicorette®).
- The registration process was streamlined and the NRT products covered by the Program were made available directly through community pharmacies only.
- Following the completion of the third competitive tender, as of January 1, 2021, the Program provides coverage of coverage for 1 brand of nicotine gum (Nicorette®), 1 brand of nicotine patches (Nicoderm®) and 1 brand of nicotine lozenge (Nicorette®).
- Each calendar year, eligible BC residents can get coverage for either 1 NRT product or 1 prescription drug for a single course of treatment that lasts for up to 12 consecutive weeks (84 consecutive days). Patients receive a 28-day supply at a time, up to a maximum of 3 fills of 28 days each.
- All BC smokers and users of other tobacco products with active coverage through the province's Medical Services Plan are eligible for nicotine gum or patches. The prescription drugs are covered through Fair

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[1] BC Stats (2020). *Report on the B.C. Smoking Cessation Program Evaluation Survey.* Retrieved from the BC PharmaCare website https://www2.gov.bc.ca/assets/gov/health/health-drug-coverage/pharmacare/bc_smoking_cessation_survey_evaluation_20201116.pdf

[2] Statistics Canada. (2021). Table 13-10-0096-10 Smokers, by age group . Retrieved January 15, 2021, from https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310009610

[3] Canadian Collaboration for Drug Safety, Effectiveness and Network Meta-Analysis (2014). A Systematic Review and Network Meta-Analysis of Combined Pharmacologic and Behavioural Intervnetions for Smoking Cessation. Ottawa: University of Ottawa Heart Institute.

PharmaCare, Plans B, C, G and W (First Nations Health Benefits), and the usual PharmaCare plan rules apply, including deductibles and co-payments.

- On February 14, 2012, the Program expanded to all federally-insured patients with active Medical Services Plan or PharmaCare coverage, providing additional coverage to supplement their existing federal drug benefits for smoking cessation aids. The Program has an expected seasonal pattern that includes a spike during launch and each January, with a decline during the rest of the year.
- In 2015, the Ministry completed the Program evaluation through numerous avenues. This evaluation involved multiple areas of the Ministry, including Pharmaceutical, Laboratory and BloodServices Division, HealthLink BC, Population and Public Health Division, as well as BC Stats, the provincial statistical agency.
- An *impact* evaluation to assess the effectiveness of the NRT component of the Program found a 27% quit rate; 76% of respondents reported that they were smoking less than before; 71% of respondents stopped smoking for at least 24 hours; 52%remained smoke free for more than 30 days after using the Program; and 65% reported that the Program helped, or is helping, them quit smoking.
- In another impact evaluation, in March 2020, BC Stats surveyed 4,000 Program clients to assess the effectiveness of both the NRT and prescription components of the Program. While the 2020 evaluation sought to replicate the 2015 evaluation, the results had limited comparability due to key methodological differences. The overall quit rate was 37%. For those who did not quit, the average amount smoked dropped from 17 to 11 cigarettes a day. A majority of respondents (66%) said the program was helpful.[1]
- From September 30, 2011 to September 30, 2020, over 364,400 patients received smoking cessation aid (303,900 for nicotine gum, inhaler, lozenge or patches, and 121,300 for bupropion or varenicline), and the Ministry has invested approximately $116.9 million for product coverage.[4]
- Coverage for nicotine replacement therapy products is available in Quebec and the Northwest Territories, in addition to BC. Coverage for at least one of bupropion or varenicline is available in all the provinces and in the Yukon, and the Northwest Territories.

## FINANCIAL IMPLICATIONS

- Total expenditure on product coverage was $116.9million ($101.5million for NRT and $15.4 million for prescription drugs) from September 30, 2011 to September 30, 2020.[4]
- The annual cost for smoking cessation drug coverage through the PharmaCare program decreased by a little under $0.5 million or 3.3% from 2018/19 to 2019/20 ($15.1 and $14.6 million respectively).[4]
- The cost of the 2020 BC Stats smoking cessation evaluation survey is $125,000: $97,000 in 2019/20 and $28,000 in 2020/21.

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**Approved:**

January 25, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
January 28, 2021 - Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
February 10, 2021– Peter Klotz A/CFO obo Philip Twyford ADM, Finance and Corporate Services Division

[4] PharmaNet data, Health Sector Information, Analysis and Reporting, January 28, 2021

# LEGISLATIVE SESSION - FACT SHEET

## 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. There are over 300 Limited Coverage drugs (LCD) on the PharmaCare formulary.
- To receive coverage, the patient's prescriber must submit a request to the Ministry of Health. If the Ministry approves the request, the drug is covered up to the patient's usual PharmaCare plan and coverage limits.
- SA coverage may be for a limited time; for example, 6 months or indefinitely, depending on the specific drug and condition being treated.

### CURRENT SITUATION

- The SA program currently receives up to 2,000 requests a day, mostly submitted via facsimile (92% of overall incoming volume); the average processing time for standard requests, from the time a request is retrieved from the queue to the time it is adjudicated and keyed into PharmaNet, is approximately 40 minutes.
- There is an 80% approval rate and coverage entry into PharmaNet by SA staff is 95+% accurate.
- The current SA request submission process still involves manual paper applications, which has posed the following difficulties:
    - Inefficient process with lots of errors and missing information;
    - Technicians and pharmacists spend too much time deciphering and researching information;
    - Time consuming for prescribers; and
    - Patients have limited access to their SA information.
- For comparison, the average phone call wait time for prescribers requesting SA via the urgent phone line (8% of overall incoming volume) is 30 seconds.
- In an attempt to expedite certain straightforward requests, effective July 26, 2019, the SA program offered accelerated, partly automated adjudications, via the interactive prescriber info line.
- The SA unit processes around 260,000 requests per year and can experience periods of backlog and reduced throughput due to the high-touch, manual nature of the process. During backlogs, patients may wait many weeks for access to their drug coverage and this may lead to a patient delaying or not initiating needed drug therapy.
- In December 2019, the electronic SA project received approval for capital funding, and a new Master Project Plan was launched as the newly named Special Authority Transformation (SAT) project to transform the SA program by digitizing the end-to-end lifecycle of requests.
- PharmaCare has launched the first phase for the SAT project through the design platform provider SalesForce. The new SAT system will: improve service delivery for provider and patient experience with timely approvals and access to coverage information; improve program process and efficiencies including automating adjudications and data entry; and improve cost-effectiveness of drug therapy decisions by validating and auditing clinical coverage criteria.
- The SAT project, as of January 2021, has achieved the following: extensive external stakeholder engagement; conversion of all SA forms to the new electronic SA form platform, io.forms, with PHSA; and has developed a SalesForce case management platform with PwC contracted to implement it.
- Implementation of the new digital platforms and process will be phased in through spring/summer 2021.
- As of April 15, 2021, the accelerated adjudication phone line was phased out due to the implementation of the SAT digital submission system for drug coverage requests.
- In May 2021, the SA team started the testing ground for an eForms Pilot Release project, in which several prescriber participants submitted SA drug coverage requests via the new eForm submission system for adjudication. There are currently 60 drugs available for adjudication via the eForms submission system in the SalesForce platform.
- To date, PharmaCare has processed 10,913 SA drug coverage requests through the SalesForce platform in the new SAT digital submission system. **Note:** This total includes the faxed drug request submissions as well as a few eForm submissions received in the eForms Pilot Release project.

# LEGISLATIVE SESSION - FACT SHEET

## KEY FACTS

- Below is a list of drug categories that require adjudication through the SA process:
    - All LCD;
    - Reference Drug Program (RDP) drugs – PharmaCare fully covers only the less costly drugs in an RDP category. If a patient cannot take the less costly, fully covered drug for medical reasons, a prescriber can request SA coverage;
    - Low Cost Alternative drugs – if a patient cannot take a lower cost version of a drug, a prescriber can request coverage of another version of the drug;
    - Limited coverage Psychiatric Medications Program (Plan G) drugs – some drugs are covered under this plan only if a patient has SA approval;
    - Out-of-province transplant drugs;
    - Compounded preparations for medications that are not commercially available; and
    - Some non-benefit drugs – exceptional last resort drug coverage.
- The SA program is also responsible for providing access to exceptional Plan G (Psychiatric Drug Plan) and Plan P (Palliative) coverage.
- Currently, when a coverage decision is reached, SA informs the prescriber by facsimile. Instead of providing prescribers with the adjudicated SA request form as a coverage decision, SA staff are sending prescribers faxlets that include the necessary SA drug coverage decision information for their patients. It is up to the prescriber to notify the patient of SA's decision.
- PharmaCare has now begun to roll out the new SAT digital submission system for adjudication, in stages, and the new system will include receiving eForm submissions from prescribers; thefore, SA coverage decisions will be provided electronically.
- Patients will also be able to access their own SA coverage status information electronically through the Patient Health Gateway portal.
- SA coverage is valid from the date that approval is entered into a patient's record on PharmaNet (BC's electronic network linking all of the province's community pharmacies) up until the coverage expiry date, if applicable. An SA must be in place before the drug is purchased, as no retroactive coverage is permitted.
- In order 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 an SA request is considered part of a prescriber office visit and therefore prescribers should not be charging patients for completing the SA forms.
- SA requests are prioritized by date received and by urgency. The target response times are one business day for urgent requests, and ten business days for regular medication requests.
- SA receives assistance from several Drug Benefit Adjudication and Advisory Committees (DBAACs), which review complex or exceptional requests. DBAAC members are contracted, practicing physicians who have expertise in a particular therapeutic area. There are DBAACs for rheumatology and autoimmune diseases; psoriasis; hepatitis; pulmonary arterial hypertension; Crohn's disease; and multiple sclerosis.
- Most of PharmaCare's drug listing decision outcomes that are based on recommendations issued by the Common Drug Review and BC's Drug Benefit Council are to list drugs as Limited Coverage with criteria.

## FINANCIAL IMPLICATIONS

- LCD expenditures for 2019/2020 were $660 million of the total PharmaCare drug (ingredients) spend of $975 million.[1]
- Drugs covered through the SA program represent 68% of total PharmaCare annual drug expenditures for 2019/2020.[1]

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**Approved:**

June 7, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
June 7, 2021 - Christine Voggenreiter, obo Martin Wright, ADM, Health Sector Information, Analysis, & Reporting
June 8, 2021 - Brenda Rafter, obo Philip Twyford, ADM, Finance and Corporate Services Division

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[1] Health Sector Information, Analysis and Reporting, PharmaNet, June 7, 2021

# LEGISLATIVE SESSION - FACT SHEET

## Substance Use Disorder Drug Coverage

### TOPIC

- Since 2017, the BC Centre on Substance Use (BCCSU) has released several guidance documents: Guidance for Clinical Management of Opioid Use Disorder (OUD), Guidance for Injectable Opioid Agonist Treatment (iOAT) for OUD, and, most recently, Risk Mitigation in the context of dual public health emergencies.
- The guidelines provide evidence and guidance to clinicians for the use of oral methadone, oral buprenorphine-naloxone, oral morphine, injectable hydromorphone (HDM) and injectable diacetylmorphine (DAM) in patients who require treatment of OUD. Due to regulatory restrictions related to DAM the iOAT Guidance focuses primarily on the use of HDM for iOAT.
- In October 2020, under orders from the Provincial Health Officer, Minister Dix approved the expansion of coverage for a range of opioid and stimulant Pharmaceutical Alternatives (PA) to assist with separating people from the toxic, lethal street drug supply. Clinicians have not yet developed the recommendations regarding which drugs to provide but current discussions are focused on injectable HDM and fentanyl alternatives such as patches.

### CURRENT SITUATION

- PharmaCare provides coverage for the oral drugs, as outlined in the various BCCSU Guidance documents under Fair PharmaCare, Plan G (Psychiatric Medications) and Plan C (Recipients of Income Assistance).
- PharmaCare provides coverage for hydromorphone 50 mg/mL injectable through the use of a Collaborative Prescribing Agreement (CPA) between PharmaCare and iOAT-trained prescribers.
- DAM for iOAT is imported from Switzerland via the Special Access Program and funded through a Health Canada grant and delivered via Health Authority iOAT programs through selected HA pharmacies.
- Coverage for the PA is currently under Fair PharmaCare, Plan G and Plan C while planning for an additional specific coverage plan for PA is underway.

### KEY FACTS

Methadone/Methadose

- Methadone maintenance treatment (MMT) is the daily oral administration of methadone as a substitute for dependence on opioids.
- Effective March 1, 2014, the Ministry changed coverage from a compounded methadone 1mg/mL solution to the commercially available Methadose (methadone) 10mg/mL to improve patient safety and reduce the variability associated with compounded methadone. The College of Pharmacists of BC (CPBC) Professional Practice Policy for MMT was updated to reflect that only commercially available 10 mg/mL solution could be dispensed.
- Methadone is the same active ingredient found in all compounded and commercially available methadone products however the switch to Methadose was disruptive for some patients. As a result, the BC Association of People on Methadone (BCAPOM) strongly advocate for the return of the compounded methadone formulation as a regular PharmaCare benefit.

Additional Methadone 10 mg/mL solutions (Metadol-D, Methadone Sandoz/Sterinova)

- In response to the BCAPOM concerns PharmaCare added additional commercial methadone options to provide people on MMT with alternative methadone products.
- On May 28, 2019, Metadol-D became a regular Pharmacare benefit for use as OAT.
- Metadol-D is clear and tasteless, and must be diluted to 100 mL in a beverage prior to dispensing.
- Methadone 10 mg/mL, Sandoz/Sterinova, was also added as a PharmaCare benefit.
- As of September 30, 2020, there were 3,788 people using Metadol-D and 124 on Sterinova[1].

[1] HSIAR methadone monthly utilization report, February 8, 2021

Compounded methadone 10 mg/mL

- As of October 1, 2019, PharmaCare coverage of compounded methadone 10 mg/mL became available on an exceptional, last resort basis when reasonable trials of 2 commercially available methadone options (Metadol-D plus one other) have resulted in failure or severe intolerance.
- Coverage criteria and procedures were developed in collaboration with the Overdose Emergency Response Centre (OERC), MMHA, CPBC, BCAPOM, BCCSU and MOH staff.
- The Product Distribution Centre (PDC) is the central hub for provision of the compounded methadone
- As of February 1, 2021, over 600 people have been approved for coverage, 19 of whom are on therapy[2].

Buprenorphine with naloxone (Suboxone and generics)

- On October 13, 2015, BC PharmaCare changed coverage for Suboxone and generics from limited coverage to a regular benefit based on new clinical data, changes in practice, and cost.
- On July 1, 2016, the CPSBC changed the prescribing requirements for Suboxone and generics to treat opioid addiction, enabling any trained physician to prescribe.

Slow-Release Oral Morphine (Kadian)

- As of June 5, 2017, Kadian slow-release oral morphine for OAT is covered under Fair PharmaCare and other drug plans, including Plan G (Psychiatric Medications Plan) and Plan C (Recipients of Income Assistance). Only the brand name Kadian 24-hour formulation of slow-release oral morphine is recommended for OAT.

Hydromorphone 50 mg/mL injectable

- Effective February 5, 2018, PharmaCare changed the coverage status of HDM injectable 50 mg/mL to allow for ongoing access and coverage for iOAT patients (through a CPA).
- In 2019, Health Canada approved HDM injectable for iOAT but it has not been reviewed by the Common Drug Review or the Drug Benefit Council for iOAT coverage.
- HDM in 5, 10 and 20 mg/mL strengths are regular benefits and 50 mg/mL is a limited coverage drug for pain.

Buprenorphine extended-release (Sublocade)

- In 2019, Health Canada approved Sublocade for the management of moderate to severe opioid use disorder in adult patients who have been inducted and clinically stabilized on a transmucosal buprenorphine-containing product.
- Sublocade requires once-monthly injections. The oral drugs for treatment of OAT all require daily ingestion, and the injectable drugs may require one or more injections per day.
- As of April 30, 2020, PharmaCare listed Sublocade as a limited coverage benefit for OAT.

Fentanyl patches

- Fentanyl is found in the majority of the street opioid supply and fentanyl addiction as risen. The fentanyl patch provides a safer alternative for those who have now developed an addiction to the fentanyl.
- Patch coverage criteria are under revision to allow coverage for opioid use disorder without pain.

## FINANCIAL IMPLICATIONS

- In 2019/20, BC's OAT program reached 27,893 BC residents (3,000 in the 1990s).[3]
- PharmaCare's related expenditures for MMT were approximately $49.76 million for 19,421 clients in 2019/20 (including drug cost, dispensing fees, and witnessed ingestion fees).
- Suboxone and generics expenditures were approximately $12.44 million for 9,799 clients in 2019/20.
- PharmaCare's related expenditures for Kadian slow-release oral morphine for OAT were approximately $12.04 million for 3,566 clients in 2019/20.

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**Approved:**

February 3, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory & Blood Services Division
February 23, 2021 – C. Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Division
April 6, 2021 – Peter Klotz, A/CFO obo Philip Twyford ADM, Finance and Corporate Services Division

[2] Special Authority, Pharmaceutical, Laboratory & Blood Services, September 16, 2020
[3] PharmaNet, Health Sector Information, Analysis and Reporting, Feburary 11, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Therapeutics Initiative

### TOPIC

The Therapeutics Initiative (TI) is an independent organization carrying out research and evaluation of pharmaceuticals. The organization is made up of physicians, pharmacists, and other researchers. It operates at arm's length from government and independently from the pharmaceutical industry and other vested interest groups.

### CURRENT SITUATION

- Current Shared Cost Agreement between the Ministry of Health and TI took effect in October 2017 and is worth $2 million per year until March 31, 2023.
- The TI conducts clinical evidence reviews, utilization reviews and drug reviews, pharmacoepidemiological studies/program evaluations, collaborative training with Ministry staff, a quality prescribing program, educational programs, and systematic reviews.

### KEY FACTS

- The TI was formed in 1994 and is part of the Department of Anesthesiology, Pharmacology & Therapeutics at the UBC Faculty of Medicine. The TI has been funded through agreements between the Ministry and the UBC Faculty of Medicine.
- In September 2012, the TI transfer under agreement contract was temporarily suspended as part of the Ministry-wide data investigation. In October 2013, the investigation concluded and in February 2014, the contract with the UBC Faculty of Medicine was reinstated.
- At that time, the TI provided services to the Ministry through one contract for clinical evidence reviews with the Ministry's Pharmaceutical Services Division, and a transfer under agreement for pharmacoepidemiological evaluation and education with the Ministry's Partnerships and Innovation Division.
- In October 2017, the 2 contracts were consolidated and additional services to be provided by the TI were agreed upon. The current contract is worth $2 million per year until March 31, 2023.
- Additional services include utilization reviews and drug reviews, pharmacoepidemiological studies/program evaluations, collaborative training with Ministry staff, a quality prescribing program, educational programs, and systematic reviews.
- In March, 2021, the Ministry provided a one-time transfer of $12 million to UBC to establish an endowment fund for the purpose of supporting new faculty positions in the TI to carry out evidence-based drug assessments, analytics and educational programs and generally to advance the goals of UBC.
- The Ministry makes PharmaCare coverage decisions based on a range of considerations including existing PharmaCare policies, programs, therapeutic options, resources and the evidence-informed recommendations of an independent advisory body called the Drug Benefit Council (DBC). The Chair of the DBC also provides oversight and advice to the Ministry and the TI through governance committees.
- Prior to the establishment of the national Common Drug Review (CDR) in 2003, the TI provided most reviews of drug submissions to the DBC. Since 2003, the majority of newly patented drugs are reviewed by the CDR.
- In the 1990s and early 2000s, the TI contributed to a number of reviews of expensive, widely prescribed drugs that assisted PharmaCare in its decisions. Some examples include proton pump inhibitors for various gastrointestinal diseases, rofecoxib (Vioxx) for pain, pioglitazone and rosiglitazone for diabetes. Rofecoxib was later removed from the market and rosiglitazone was severely restricted, due to safety concerns.
- The DBC is responsible for making drug listing recommendations to the Ministry and the Ministry is ultimately the decision-maker. The TI still contributes to DBC recommendations by providing evidence-based clinical, pharmacoepidemiological and therapeutic reviews.
- TI work is now underway on various projects to better support BC health providers and the Ministry in making evidence-informed decisions with pharmaceuticals, including:

- Publishing the Therapeutics Letter (TL) and hosting various educational events which provide evidence-based information on various clinical areas for healthcare professionals and policy makers.
- Pharmacoepidemiological studies and/or program evaluations to investigate the safe and effective use of drugs in the BC population.
- A quality prescribing program, "Portrait", provides prescribers with feedback on their prescribing patterns for selected therapeutic areas (similar to the previous EQIP or Education for Quality Improvement in Patient Care program).
- Utilization reviews and drug reviews regarding therapeutic evaluation of single drugs, drug classes and therapeutic areas.
- Cochrane Hypertension systematic reviews and protocols via infrastructure and editorial base for Cochrane Canada.
- Collaborative training opportunities with Ministry staff on pharmacoepidemiological studies and/or program evaluations.
- Collaborating with the Ministry (Pharmaceutical, Laboratory and Blood Services Division) to support the Ministry's decision making on new drug listings and other pharmaceutical policies.

## FINANCIAL IMPLICATIONS

- In October 2017, the TI's 2 contractual arrangements with the Ministry were consolidated into a single shared cost arrangement.
- The shared cost arrangement spans 2017/18 - 2022/23, at $1.41 million in 2017/18 and $2 million per fiscal year thereafter.
- In 2020/21 MoH provided a one-time transfer of $12 million to UBC to establish an endowment fund.

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**Approved:**
June 10, 2021- Brenda Rafter obo Philip Twyford ADM, Finance and Corporate Services Division
June 8, 2021 - Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Type 2 Diabetes Drugs

### TOPIC

- Type 2 diabetes is a medical condition that occurs when the pancreas produces insufficient amounts of insulin and/or the body's tissues become resistant to insulin.
- For Type 2 diabetes, oral drugs, with or without insulin, are the standard therapy.
- PharmaCare provides coverage for many drugs for the treatment of Type 2 diabetes and has several newer drugs under review.

### CURRENT SITUATION

- The Ministry provides PharmaCare coverage for a number of diabetes therapies, including:
    - metformin;
    - the sulfonylureas gliclazide and glyburide;
    - the thiazolidinedione pioglitazone;
    - the dipeptidyl peptidase-4 (DDP-4) inhibitors linagliptin, linagliptin-metformin, saxagliptin and saxagliptin-metformin
    - the sodium-glucose transport protein 2 inhibitor (SGLT-2) empagliflozin and empagliflozin-metformin;
    - the glucagon-like peptide 1 receptor agonist (GLP1 agonist) subcutaneous semaglutide; and
    - many different types of insulins.
- PharmaCare is currently reviewing the following Type 2 diabetes treatments:
    - canagliflozin (Invokana); and canagliflozin-metformin (Invokamet); and
    - insulin lispro biosimilar (Admelog).

### KEY FACTS

- Metformin is considered a first-line therapy; gliclazide, glyburide and insulins are considered to be second-line therapies while pioglitazone, linagliptin, saxagliptin, empagliflozin, and semaglutide are considered to be third-line products, to be used after using a combination of metformin and another drug.
- PharmaCare covers the third-line products as Limited Coverage benefits through the Special Authority program.
- PharmaCare provides coverage for biosimilar insulin glargine (Basaglar) as a Limited Coverage benefit under the PharmaCare program and as a Regular Benefit for PharmaCare Plan W (First Nations Health Benefits).
- In the first phase of the Biosimilars Initiative, from May 27, 2019 to November 25, 2019, patients using insulin glargine (Lantus) for treatment of Type 1 and Type 2 diabetes were switched to the biosimilar insulin, Basaglar.

<u>Newer Diabetes Drugs</u>

- Newer classes of drugs for treatment of Type 2 diabetes include the SGLT-2 inhibitors (canagliflozin, dapagliflozin, empagliflozin, and ertugliflozin), and the GLP-1 agonists (dulaglutide, exenatide, liraglutide, lixisenatide and semaglutide ).
- PharmaCare recently reviewed the following drugs and decided not to provide coverage for the treatment of Type 2 diabetes:
    - dapagliflozin (Forxiga) and dapagliflozin-metformin (XigDuo);
    - dulaglutide (Trulicity);
    - ertugliflozin (Steglatro) and ertugliflozin-metformin (Segluromet);
    - exenatide (Byetta)
    - insulin degludec (Tresiba) and insulin degludec plus liraglutide (Xultophy);
    - liraglutide (Victoza);
    - lixisenatide (Adlyxine); and
    - lixisenatide plus insulin glargine (Soliqua);.

- In May 2017, CADTH published a Therapeutic Review Report for second-line therapies.[1] CADTH recommended, as no one drug class showed any clear superiority in efficacy or safety outcomes, the drugs that provide the best value for money for second-line treatment are the sulfonylureas (gliclazide and glyburide).
- In patients with Type 2 diabetes and established cardiovascular disease, CADTH found there is not enough evidence to make a general recommendation for a whole drug class but supported the individual drug recommendation for empagliflozin to reduce the incidence of cardiovascular death.

## FINANCIAL IMPLICATIONS

PharmaCare spending for diabetes medication and supplies coverage increased by $4.20 million or 5.5% from 2018/19 to 2019/20 ($76.03 million and $80.23 million respectively).[2]

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**Approved:**

January 27, 2021 –Mitch Moneo, ADM, Pharmaceutical, Laboratory and Blood Services Division
February 17, 2021– Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting Division
February 18, 2021– Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] See https://www.cadth.ca/drugs-type-2-diabetes-second-and-third-line-therapy-review-update, accessed January 28, 2020.
[2] PharmaNet, Health Sector Information, Analysis, and Reporting Division, February 2, 2021.

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# LEGISLATIVE SESSION - FACT SHEET

# Auditor General Report on Drinking Water 2019

## TOPIC

In July 2019, the Office of the Auditor General (OAG) released an audit report "The Protection of Drinking Water" (OAG Report) that identified several recommendations for the Ministry of Health (HLTH) and the Office of the Provincial Health Officer (PHO) to improve drinking water protection.

## CURRENT SITUATION

- HLTH presented a comprehensive action plan to address the OAG recommendations that was accepted at the Public Accounts Committee on Dec. 17, 2019. On March 24, 2021, HLTH and the PHO provided an annual progress update to PAC on the work outlined in its action plan and indicated progress delays.
- COVID-19 has had a significant impact on advancing HLTH's action plan; ministries involved in water, as well as health authority (HA) staff who have been re-deployed to COVID, have identified limited availability and capacity for engagement to advance the actions.
- HLTH is making progress with actions and projects are underway. The magnitude and complexity of actions require some projects to be completed before initiating further actions.

## KEY FACTS

- The OAG referenced the Province's 2002 "Action Plan for Safe Drinking Water in British Columbia" (Action Plan) as a benchmark on HLTH's responsibilities for drinking water leadership to undertake the audit of the drinking water program delivered by HTLH and the PHO.
- Provincial leadership and the legislative framework have changed significantly since 2002. The OAG report did not recognize the transfer of leadership responsibilities from HLTH to the Ministry of Environment (ENV) in 2006. Source water protection is a multi-agency responsibility, including HLTH's responsibility for drinking water systems and ensuring tap water is potable.
- The OAG concluded that HLTH and the PHO are not taking the needed actions to protect drinking water in BC and made eight recommendations to address the issues with five recommended specific to HLTH, two to the PHO and one with joint action required as follows:
    1. HTLH to lead review of legislation affecting drinking water to inform risks and legislative gaps.
    2. HTLH to lead cross-ministry coordination of strategies to address risks to drinking water.
    3. HLTH to develop a provincial strategic plan for the protection of drinking water including prioritized activities based on the risks identified in an integrated (interoperable) province-wide data system.
    4. HLTH to identify risks to source protection, drinking water treatment, distribution and small water systems; mitigate identified risks; and evaluate and adjust guidelines to ensure they are effective.
    5. PHO to take action to improve oversight of drinking water.
    6. HLTH and PHO to review the legislative provisions regarding drinking water protection plans.
    7. HLTH to report out to the public on progress on improving the protection of drinking water.
    8. PHO to report out on a timely basis progress and trends in drinking water protection.
- PHO office is leading the response on #5, 6 and 8. Information on these are not included in this fact sheet.
- Committed actions and project status under the HLTH action plan are summarized as follows:

<u>Recommendations #1 & #2:</u>

In collaboration with its cross-ministry partners and the PHO, and further to the obligations with respect to the UN Declaration on the Rights of Indigenous People, lead a formal review of policy and legislation to identify recommendations for Government's consideration on the improvements that can be made to further protect drinking water and to clarify Ministries' roles and responsibilities.

- **Status:** In Progress - Econics Services Inc. was hired to undertake the legislative review, stakeholder engagement and literature review to support the identification of gaps, challenges and opportunities to strengthen the protection of drinking water in B.C., as well as to clarify Ministries' roles and responsibilities with respect to source water protection. The final report was delivered in March 2021.
- A cross ministry Executive Directors Committee was formed (January 2021) to collaboratively address recommendations in the OAG report and contribute to a final Provincial Strategy on Drinking Water. The

Econics report was shared with the EDSC-DW at the February meeting. The goal is to bring forth recommendations for government consideration in January 2022.

Work is also underway on small water systems with BC Water and Waste Association (BCWWA) to expand their program on "Building Sustainable Small Water Systems in BC". The project is intended to build small water system capacity to improve their management and sustainability in providing safe drinking water.

- **Status: In Progress** – This builds on an earlier pilot project which reached over 100 small systems in BC with training and resources. A shared cost agreement with BCWWA for "Small Water Systems 2.0" project was signed in February 2020, to expand on training opportunities and resources.

Recommendation #3:

Lead the development of a provincial strategic plan based on information identified from an inter-operable province-wide data system.

- **Status: In Progress** Work is under way with HAs and contractor *MNP LLP* to standardize business processes within the drinking water program. The contractor is currently engaging with HAs on the project charter and engagement plan for this multi-year and multi-stage project and is expected to be finalized in early May. These practices, once developed, will support a provincial drinking water system and serve as performance indicators.
- Collaboration is occurring with Health Sector Information Management and Information Technology Division to put forward a proposal to Office of the Chief Information Officer for a system that collects HA water-related data. The team also met with the Ministry of Environment team responsible for water data to discuss how their data system may be integrated to be interoperable with our proposed system. In February 2021, the Office of the Chief Information Officer's (OCIO) Digital Investment Board approved funding and HLTH is now working on the business case for submission to the OCIO in July 2021.
- Two contracts with WSP Canada Group Ltd. contracts (Design Guidelines for Drinking Water Systems and Emergency Response Plan & Water User Communication Plan) are underway.
- Together, these actions will support the development of the strategic plan. Other components informing the plan are dependant on deliverables related to recommendations 1 and 2.

Recommendation #4:

Work with partner agencies to undertake risk identification and co-ordination to address risks with Ministries and agencies.

- **Status: Not Yet Initiated -** dependant on deliverables and outcomes of recommendations 1, 2 and 3.

Develop a process to review, evaluate, monitor and adjust guidelines for drinking water protection.

- **Status - In Progress –** a Project Initiation Document for this project has been drafted.

Recommendation #6:

In collaboration with PHO, review Drinking Water Protection Plans under the *Drinking Water Protection Act*.

- **Status: Initiated –** HLTH and PHO are developing a plan to assess what the impediments are to the implementation of Drinking Water Protection Plans are and how to address them.

Recommendation #7:

Develop a reporting framework and report on the progress to improve drinking water to the people of BC.

- **Status: Initiated –** HLTH and the PHO are currently reviewing roles and responsibilities to distinguish mandates on reporting to the public on progress on drinking water protection. The interoperable data project will help assess what parameters to report on in the future.

## FINANCIAL IMPLICATIONS

Government Financial Information

# LEGISLATIVE SESSION - FACT SHEET

Government Financial Information

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**Approved:**

February 12, 2021 – Peter Klotz, A/CFO obo –Philip Twyford, ADM, Finance and Corporate Services Division
April 26, 2021– Lorie Hrycuik, Executive Lead, Population and Public Health
April 26, 2021 - Ian Rongve, ADM, COVID Response and Health Emergency Management Division

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Infection Prevention and Control Guidance

## TOPIC

Provincial guidance for the prevention and control of COVID-19 in BC health care settings.

## CURRENT SITUATION

- The Ministry of Health supports the provincial pandemic response by issuing best practice guidance for infection prevention and control (IPC) in BC health care settings.
- The Ministry's IPC 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 (PICNet), BC Centre for Disease Control (BCCDC), the Office of the Provincial Health Officer (PHO), First Nations Health Authority, and other health system partners.
- BC's approach to stopping COVID-19 transmission is grounded in a comprehensive hierarchy of infection prevention and exposure control measures for communicable disease. This includes the following measures:
  - Population-level measures (crowd limits, quarantine/isolation, contact tracing, testing).
  - Environmental measures (physical distancing, physical barriers, ventilation, cleaning and disinfection).
  - Administrative measures (screening, changes in work practices, decreased density of individuals).
  - Personal measures (staying home when sick, hand hygiene, respiratory etiquette).
  - Personal protective equipment (PPE) (masks, eye protection, gown, gloves).
- In September 2020, the Ministry's *Management of COVID-19: Health Sector Plan for Fall/Winter 2020/21* outlined IPC-related actions for the health system:
  - Strengthening standards and guidelines on IPC best practices in Home and Community Care (HCC), Long Term Care and Assisted Living (LTC/AL) and acute care, including management of outbreaks.
  - Establishing requirements for monitoring and reporting on consistent IPC practices across all LTC/AL and acute care sites, including staff training for IPC such as the appropriate and safe use of PPE.
  - To protect vulnerable seniors, implementing robust IPC practices across all HCC, LTC/AL settings, with an additional 2,000 staff.

## KEY FACTS

Infection Control Policies & Guidance

- On March 20, 2020, the Ministry and PHO issued *Policy Communique 2020-01: Infection Prevention and Control for COVID-19* to health authority CEOs with requirements to implement IPC guidance to stop the transmission of COVID-19 in acute care, LTC and AL settings. *Policy Communique 2020-01* was updated on May 19, 2020[1] with revised guidance for LTC and AL settings and expanded criteria for essential visitation.
- On March 25, 2020, the Ministry issued the *Emergency Prioritization in a Pandemic Personal Protective Equipment Allocation Framework*[2] (PPE Framework) to provide direction to the health system on the use of PPE during the pandemic to protect health care workers (HCW) while managing the critical supply chain during a period of significant global disruption.
- On November 4, 2020, *Policy Communique 2020-11*: *Mask Use in Health Care Facilities During the COVID-19 Pandemic* outlined Ministry requirements for mask use by health care workers, non-clinical staff, patients and visitors to prevent the transmission of COVID-19[3].
- To date, the Ministry has published over 40 provincial IPC guidelines and resources for stopping the spread of COVID-19 in health care settings. These include:
  - Sector-specific infection control guidance for LTC and AL facilities, HCC, community-based clinician offices, allied health care providers, BC Emergency Health Services (BCEHS), community pharmacies, coroner services, as well as food and environmental service providers[4].

[1] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/covid-19-infection-prevention-control.pdf
[2] http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_ppe_allocation_framework.pdf
[3] http://www.bccdc.ca/Health-Professionals-Site/Documents/Mask_Use_Health_Care_Facilities.pdf
[4] http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/infection-control

  - Screening and risk assessment tools, including COVID-19 screening tools for direct patient care interactions and facility entrances, a Point of Care Risk Assessment tool to guide the selection of appropriate IPC actions and PPE, HCW self-assessment and safety checklists, and standardized criteria for assessing HCW exposures to COVID-19[5].
  - Posters to promote best practices, including the appropriate donning and doffing of PPE, use of face masks, hand washing, physical distancing, cleaning and disinfection[6].
- In accordance with the *Health Sector Plan for Fall/Winter 2020/21,* all provincial IPC best practice guidance documents for Home and Community Care, Long Term Care and Assisted Living and acute care, including management of outbreaks, have been updated and strengthened to reflect emerging scientific evidence and current expert recommendations for prevention and controlling COVID-19.

IPC Assessments

- In October 2020, in line with the *Fall/Winter Plan* actions, the Ministry conducted a review of current IPC assessment programs in health authorities for hand hygiene compliance, environmental cleaning, appropriate use of PPE and medical device reprocessing (i.e., the cleaning, disinfection and sterilization of re-usable medical devices).
- Health authorities were surveyed on implementation of IPC guidelines and assessments, including visitor/staff screening and COVID-19 outbreak response for acute care, LTC/AL and HCC in order to identify gaps and mitigating actions.
- Recommendations are forthcoming based on the provincial analysis of the HA IPC assessment submissions for consideration.

The Provincial COVID-19 IPC/Workplace Health and Safety (IPC/WHS) Task Group

- On January 27, 2020, the Ministry and the Office of the Provincial Health Officer activated emergency management protocols for COVID-19, including the formation of the Provincial IPC/WHS Task Group as a subcommittee under the broader provincial response structure.
- Co-chaired by the Ministry, PICNet and provincial WHS representatives, the Task Group includes IPC and WHS leads from each health authority, including First Nations Health Authority and Provincial Health Services Agency, as well as BCEHS, College of Physicians and Surgeons of BC and BCCDC.
- The IPC/WHS Task Group provides IPC recommendations for health care settings and provides expert perspectives and reviews of provincial IPC guidance and policies for COVID-19.

## FINANCIAL IMPLICATIONS

- On June 30, 2020, the BC Government 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 to provide $10 million to enhance IPC and improve quality and safety in LTC/AL settings across the province.
- The acquisition of PPE supplies is being managed through the PHSA in consultation with the Ministry. The PPE-related costs, including possible inventory valuation adjustments that may required as a result of the year-end inventory audit review will not be available until after the close of the 2020/21 fiscal year-end and the external audit of PHSA's financial statements has been completed. This information will be publicly disclosed with the release of the Government's 2020/21 Public Accounts.

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**Approved:**

February 2, 2021 – Lorie Hrycuik, Executive Lead, Population and Public Health Division
February 3, 2021 – Brian Emerson, Deputy Provincial Health Officer
February 5, 2021 –Ian Rongve, ADM, COVID Response and Health Emergency Management Division
February 17, 2021 – Christine Voggenreiter obo Martin Wright, ADM, Health Sector Information, Analysis & Reporting
February 25, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

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[5] http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/testing-and-case-management-for-healthcare-workers
[6] http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/signage-posters
[7] Treasury Board Decision Letter dated September 2020

# LEGISLATIVE SESSION - FACT SHEET

# COVID-19 Personal Protective Equipment Framework

## TOPIC

Chronological overview of development and key messages for the COVID-19 Pandemic: BC's Personal Protective Equipment (PPE) Allocation Framework.[1]

## CURRENT SITUATION

- The COVID-19: Emergency Prioritization in a Pandemic Personal Protective Equipment (PPE) Allocation Framework was published on March 25, 2020.
- The purpose of the Framework is to provide direction to the health system on the use of PPE during the pandemic to protect health care workers (HCW) from COVID-19 amid unprecedented world-wide demand and critical disruptions to global PPE supply chains. The purpose also includes determining the type of PPE individuals working or visiting health care settings receive in the event of a pandemic when demand for PPE overwhelms supply.
- The expectation is that the Framework is used both before a pandemic as a basis for preparatory work and during an outbreak as the Framework for decision-making. As a result, it includes required actions that need to be taken to protect PPE supply at each stage of risk e.g., when PPE risk is at Stage 1, where all PPE levels are intact, appropriate alternative PPE items must be identified and contingency plans developed for implementation of alternative PPE items.
- The Framework was informed by the COVID-19 Ethical Decision-Making Framework, previous ethical guidance on provincial pandemic planning, clinical and public health experts, clinical ethicists, and infection prevention and control experts.

## KEY FACTS

- In March 2020, the Ministry of Health recognised significant challenges in maintaining PPE supplies for health care workers due to a limited stock of N95 respirators and other items.
- The limited stock was due to significant, increased use in BC, coinciding with a marked decline in PPE availability as a result of supply chains becoming significantly disrupted by limited production and exponential increases in global demand.
- Stakeholder consultations were immediately undertaken with representatives from Supply Chain, Infection Prevention and Control, Ethics, Health Emergency Management BC, Health Authorities, and the Health Emergency Coordination Centre / Ministry of Health to discuss options for managing the situation.
- These discussions:
    - Identified the need for an ethically permissible framework providing prioritization of PPE across the health care system with the goal of conserving supply and protecting HCWs.
    - Identified a table from the World Health Organization Rational Use of PPE for COVID-19 document[2] as a template for the Framework.
    - Identified priority areas, such as Critical Care/Intensive Care and Emergency, due to high risk and essential services provided by a limited pool of practitioners with specialized expertise.
    - Identified the need to prioritize N95 respirators or equivalents for HCWs performing Aerosol Generating Medical Procedures on patients with, or suspected of having, COVID-19.
- The Provincial Ethics Response Team presented draft documents describing ethical principles (respect, the harm principle, fairness, consistency, reciprocity, proportionality, procedural justice) that could be used to address three questions related to the availability of PPE:
    1. In what circumstances is it ethically permissible to use non-standard PPE supplies when appropriate PPE is not available?
    2. How should PPE resources be distributed / allocated in times of critical scarcity?

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[1] Provincial COVID-19 Task Force. COVID-19: Emergency Prioritization in a Pandemic Personal Protective Equipment (PPE) Allocation Framework. March 25, 2020. http://www.bccdc.ca/Health-Professionals-Site/Documents/COVID19_ppe_allocation_framework.pdf

[2] World Health Organization. "Rational Use of Personal Protective Equipment for Coronavirus Disease (COVID-19) and Considerations During Severe Shortages". March 20, 2020. https://www.who.int/publications/i/item/rational-use-of-personal-protective-equipment-for-coronavirus-disease-(covid-19)-and-considerations-during-severe-shortages

3. How should health care workers (HCWs) and organizations approach the ethical duty to care in the context of the COVID-19 pandemic?

- The decision was made at that time to implement extended use of PPE for all HCWs, where safe to do so, with the aim to reduce the amount of PPE being used overall. For example, in the same patient cohort, extended use would include keeping the same medical mask on between patient encounters unless damaged or visibly soiled.
- On March 23, 2020, the stakeholder group reviewed and accepted the Framework, and the Framework was published on March 25, 2020.
- Due to the focus in the Framework on the acute care sector, additional guidance requests were received from community sectors where further stakeholder consultations were held on March 26 and March 30 to seek feedback and input specific to the varied community settings and populations served.
- Additional policy for Long-Term Care and Assisted Living settings was developed and published in May 2020.[3]
- Work continued in this area as more was learned about the COVID-19 disease, as well as best practices to prevent transmission as we entered the fall/winter 2020 with the changing infection and ICU rates.
- Stakeholders, including unions, were consulted on next steps to assist the health sector to align with the provincial re-start planning and ensure PPE capacity for a potential surge in the virus transmission.
- Stakeholders from several organizations provided feedback on the Framework. These include health authorities and associated agencies, Providence Health Care, Health Sciences Association of BC, Ambulance Paramedics of BC, OHS Health Employers Association of BC (Doctors of BC, Health Science Professionals Bargaining Association, Facilities Bargaining Association, Community Health Bargaining Association, Ambulance Paramedics & Ambulance Dispatchers Bargaining Association, Hospital Employees Union, Community Health Bargaining Association, BC Government Employees Union, and Fraser Health Patient Experience).
- PPE inventories continue to be actively monitored and managed, and PPE supply chains have significantly improved since the initial phase of the pandemic.
- Considering significant improvements to PPE supply chains and provincial inventories, BC has moved from Stage 4 to Stage 1 of the Framework and health care workers are using Point of Care Risk Assessments (PCRA) to determine appropriate PPE use. Extended use of PPE is still required in all health care settings.
- Performing a PCRA is done by HCWs before every patient/resident interaction to protect the patient and other patients, as well as the HCW from the transmission and exposures of microorganisms (e.g., from sprays of blood, body fluids, respiratory secretions, and contaminated needles). This includes the HCW's determination of appropriate use of PPE based on recommended best practices to protect from transmission and exposures.
- The use of PCRAs to guide the selection of appropriate PPE fully aligns with WorkSafe BC requirements for health care COVID-19 safety plans, which stipulates that *"health care workers must engage in a point of care risk assessment for every patient or client interaction"*[4].

## FINANCIAL IMPLICATIONS

The acquisition of PPE supplies is being managed through the PHSA in consultation with the Ministry. The PPE-related costs, including possible inventory valuation adjustments that may required as a result of the year-end inventory audit review will not be available until after the close of the 2020/21 fiscal year-end and the external audit of PHSA's financial statements has been completed. This information will be publicly disclosed with the release of the Government's 2020/21 Public Accounts.

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**Approved:**

February 1, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
February 1, 2021 – Haley Miller, Office of the Provincial Health Officer
February 25, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division
April 26, 2021 – Lorie Hrycuik, Executive Lead, Population and Public Health Division

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[3] http://www.bccdc.ca/Health-Info-Site/Documents/COVID19_LongTermCareAssistedLiving.pdf
[4] WorkSafe BC. "Health care and COVID-19 safety". https://www.worksafebc.com/en/about-us/covid-19-updates/covid-19-industry-information/health-care Accessed January 29, 2021.

# LEGISLATIVE SESSION - FACT SHEET

## Fluzone High Dose for Seniors in Long Term Care and Assisted Living

### TOPIC

- On June 2, 2020, BC accepted the Government of Canada's one-time offer to purchase 45,500 doses of Fluzone HD for all seniors in BC Long Term Care (LTC) and Assisted Living facilities for the 2020/21 influenza season.
- On January 19, 2021, the Government of Canada confirmed this offer will be repeated for the 2021/22 influenza season.

### CURRENT SITUATION

- In May 2020, the Government of Canada made a one-time offering to all provinces and territories to purchase Fluzone High Dose vaccine for all individuals 65+ living in LTC settings, for the 2020/21 Influenza season.[1]
- On September 9, 2020, the Province publicly announced the 2020/21 Fluzone High Dose program for BC seniors in LTC and Assisted Living settings[2].
- Under the terms of this offering, BC was provided with 45,500 doses of Fluzone, based on July 2019 census figures.[3]
- The Government of Canada covered the costs of vaccine purchase. BC was responsible for the distribution and administration of doses.
- On January 19, 2021, the Government of Canada confirmed that the offer of Fluzone High Dose vaccine for all individuals 65+ living in LTC and Seniors' Assisted Living will be repeated for the 2021/22 influenza season.
- Fluzone HD is not a treatment or preventative measure against COVID-19.
- This offering is being made on the basis that a wave of COVID-19 *and* a wave of influenza in the fall would be a double burden on Canadian seniors living in LTC settings, the most vulnerable population at risk of severe illness and death.

### KEY FACTS

Background – Influenza and COVID-19

- Influenza is an acute respiratory illness caused by the Influenza A or B virus.[4]
- COVID-19 is an acute respiratory illness caused by the SARS-CoV-2 coronavirus.[5]
- Seniors 65 years and older, very young children, and people who have lung or heart disease, chronic health conditions or weakened immune systems are at greater risk of developing severe influenza complications.
- Similarly, older people and people with chronic health conditions such as diabetes, heart disease and lung disease are at higher risk of developing more severe illness or complications from COVID-19.
- BC's publicly-funded influenza immunization program provides influenza vaccines to people at high risk of serious illness from influenza, including the elderly and those living in LTC and assisted living settings.
- Fluzone HD is not currently included in the BC influenza immunization program.

Fluzone High Dose

- High dose trivalent inactivated influenza vaccine, also known as Fluzone High Dose, is approved for use in Canada for adults 65 years and older.
- Fluzone HD contains quadruple the amount of antigen compared to standard-dose influenza vaccine. The additional antigen content is intended to enhance the body's immune response in order to counter the common reduction in immune response that occurs with advancing age.

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[1] Email from BCCDC. Summary of FPT Discussions on High Dose Flu Vaccine. May 2020.
[2] Government of British Columbia. "News release: investment brings new support to those most vulnerable to COVID-19 and communities where they live". September 9, 2020. https://news.gov.bc.ca/releases/2020PREM0050-001694
[3] Allocation of Fluzone HD Doses paid for by the Government of Canada - by Population 65+, Public Health Agency of Canada, May 2, 2020.
[4] HealthLink BC. "Facts about influenza". https://www.healthlinkbc.ca/healthlinkbc-files/facts-about-influenza. Accessed June 9, 2020.
[5] BCCDC. "Patients at higher risk for COVID-19 complications". http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/vulnerable-populations. Accessed June 9, 2020.

- Ontario[6] and the Northwest Territories[7] are the only Canadian jurisdictions with public Fluzone HD programs for all individuals aged 65 and older at this time.
- Saskatchewan,[8] Manitoba,[9] Prince Edward Island,[10] and Nova Scotia[11] currently have public Fluzone HD programs for individuals 65 and older living in LTC settings.
- While NACI has not performed cost-effectiveness analyses to compare Fluzone HD with other influenza vaccines, there is good evidence that it provides better protection to standard dose influenza vaccines in adults 65 years of age and older.

BC's Influenza Program

- BC's publicly-funded influenza immunization program provides influenza vaccines to:
  - people most at risk of serious illness from influenza (e.g., young children, pregnant women, the elderly, those living in LTC and assisted living settings, and people with certain medical conditions);
  - people who might transmit or spread influenza to those most at risk of serious illness from influenza (e.g., health care workers); and
  - people who provide essential community services (e.g., first responders[12]).
- BC currently funds *standard* dose quadrivalent inactivated influenza vaccine (QIIV).
- Fluzone HD is not currently included in BC's influenza immunization program.
- Current evidence for Fluzone HD indicates an added benefit for seniors, compared to the 'regular' dose vaccines.[13]
- For public health immunization programs, Canada's National Advisory Committee on Immunization (NACI) recommends that *any* of the approved influenza vaccines available in Canada should be used in people 65 and over.[14]
- NACI's guidance states that there is insufficient evidence on the incremental value of influenza vaccines (i.e. cost-effectiveness assessments have not been performed by NACI) to make comparative public health program-level recommendations among the influenza vaccines that are currently available in Canada.

## FINANCIAL IMPLICATIONS

- The Government of Canada will be purchasing enough doses of Fluzone HD for the LTC and seniors' assisted living resident population in BC in 2021/22.
- Distribution and administration of the Fluzone HD doses within BC will be covered through existing immunization program budget allocations.

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**Approved:**

January 28, 2021 – Lorie Hrycuik, Executive Lead, Population and Public Health Division.
February 1, 2021 – Dr. Martin Lavoie, Deputy Provincial Health Officer, Office of the Provincial Health Officer
February 1, 2021 – Ian Rongve, ADM, COVID Response and Health Emergency Management Division
February 10, 2021 – Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

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[6] Public Health Ontario. "Influenza Vaccines for the 2019–20 Influenza Season - Focus on Adults 65 Years of Age and Over". https://www.publichealthontario.ca/-/media/documents/F/2019/fact-sheet-influenza-vaccine-2019-2020.pdf?la=en. Accessed June 9, 2020.
[7] Northwest Territories Health and Social Services. "Seasonal Influenza Program Guidelines: 2019-2020". https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/nwt-seasonal-influenza-guidelines.pdf. Accessed June 9, 2020.
[8] Saskatchewan Health Authority. "Influenza Immunization Reference Guide, 2019-2020". https://www.saskhealthauthority.ca/Services-Locations/flu/Documents/Influenza%20Immunization%20Reference%20Guide%202019-2020.pdf. Accessed June 9, 2020.
[9] Province of Manitoba. "Seasonal Influenza Vaccine for Residents of Long-Term Care Facilities". August 2019. https://www.gov.mb.ca/health/flu/docs/ltcf_hcp.pdf. Accessed June 9, 2020.
[10] Prince Edward Island Department of Health and Wellness. "Universal Influenza Program Frequently Asked Questions From Immunizers". https://www.princeedwardisland.ca/en/information/health-and-wellness/universal-influenza-program-frequently-asked-questions-immunizers
[11] Nova Scotia Department of Health and Wellness. "Publicly Funded Seasonal Inactivated Influenza Vaccine Information for 2019-2020". https://pans.ns.ca/sites/default/files/infuenza_information_for_hcp.pdf
[12] HealthLink BC. "Inactivated Influenza (Flu) Vaccine". https://www.healthlinkbc.ca/healthlinkbc-files/inactivated-influenza-vaccine
[13] BCCDC. "Fluzone High-Dose Influenza Vaccine Question and Answer Document – Update August 2019". http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Immunization/Vaccine%20Info/FluzoneHD_QandA.pdf. Pg. 3. Accessed June 9, 2020.
[14] NACI. "Canadian Immunization Guide Chapter on Influenza and Statement on Seasonal Influenza Vaccine for 2020–2021". Table 2. https://www.canada.ca/en/public-health/services/publications/vaccines-immunization/canadian-immunization-guide-statement-seasonal-influenza-vaccine-2020-2021.html#II5. Accessed June 9, 2020.

# LEGISLATIVE SESSION - FACT SHEET

## Immunization Program Update + Influenza Seasonal Program

### TOPIC

BC's publicly funded immunization program, including the 2021/22 seasonal influenza program.

### CURRENT SITUATION

- On September 9, 2020, the Province announced measures to protect the most vulnerable British Columbians by augmenting the provincial influenza immunization campaign.[1]
- As part of this, 45,000 Fluzone High Dose immunizations funded by the federal government were made available to all long-term care and seniors assisted living residents. On January 19, 2021, the Government of Canada confirmed this offer will be repeated for the 2021/22 influenza season.
- For the 2021/22 season, BC will be purchasing 2.5 million doses of influenza vaccine, a 10% increase from 2020/21.
- A provincially coordinated action plan to address the unique challenges of delivering immunization services during the pandemic is being developed by the Ministry of Health (HLTH), BC Centre for Disease Control (BCCDC) and the Office of the Provincial Health Officer in partnership with health authorities and community vaccine providers.

### KEY FACTS

- BC's publicly funded immunization program currently protects against 16 different diseases.
- The burden of illness, population characteristics and implementation feasibility vary across Canada. For these reasons, immunization schedules vary between provinces and territories.
- Immunization is not mandatory in any province or territory in Canada. Immunization is strongly encouraged to prevent illness (including severe disease and death) and outbreaks of vaccine-preventable diseases.
- Changes to BC's publicly funded immunization program are recommended by the BC Communicable Disease Policy Advisory Committee, reviewed by HLTH, with the final decision made by the Minister of Health.

<u>Strategic Direction</u>

BC's strategic direction for immunization program delivery is outlined in *Immunize BC: A Strategic Framework for Immunization in BC* (2007). Work to renew the *Strategic Framework for Immunization* is underway.

<u>Delivery of Vaccines by Health Care Professionals</u>

- Immunizations in BC are delivered by regulated health professionals including physicians, registered nurses, psychiatric nurses, licensed practical nurses, pharmacists, naturopathic physicians, and midwives.
- Since 2009, pharmacists are authorized to administer vaccines and treat anaphylaxis for individuals over 5 years old. In 2015, pharmacists were further authorized to administer intranasal drugs, including vaccines, to children 2 years and older.

<u>"Flu" (Influenza) Vaccines</u>

- The influenza season in Canada can last two to three months, and typically occurs at some point between November and April each year.

  **2020/21:**

  For the 2020/21 influenza season, the province secured 2,241,600 doses of influenza vaccine to meet the increased demand during the pandemic. This order represented a 47% increase compared to the 2019-20 season (1,522,400).[2,3]

  **2021/22:**

  For the 2021/22 influenza season, BC will be purchasing 2.5 million doses of vaccine, a 10% increase from 2020/21.
- Aligned with all other provinces, BC will be transitioning from a trivalent to a quadrivalent influenza immunization program in 2021/22 to provide added protection from four strains of influenza virus.

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[1] Government of BC. "News release: investment brings new support to those most vulnerable to COVID-19 and communities where they live". September 9, 2020. https://news.gov.bc.ca/releases/2020PREM0050-001694

[2] Ministry of Health Summary – Comparison between 2019 and 2020/21. Influenza Vaccine Measures: Vaccine Supply & Doses Administered January 6, 2021. Data report from BCCDC.

[3] MoH Summary – 2020/21 Influenza Vaccine Measures: Vaccine Supply & Doses Administered Report 10 – Jan 7, 2021

Data Collection and Reporting

- Interior Health and Island Health use Public Health Information System (PHIS; a.k.a. Panorama) to record immunizations.
- Vancouver Coastal Health and Fraser Health use the PARIS system to record immunization records administered by pharmacists and public health.
- Northern Health uses the CMOIS ("See Moys") system to record and track immunizations.
- An interface to transfer immunization data from PARIS and CMOIS to PHIS was implemented in 2019.
- The Provincial Health Services Authority (PHSA) brings together all information from PHIS, PARIS and CMOIS into the Provincial Immunization Registry to report provincial immunization coverage rates.
- First Nations Health Authority is transitioning its immunization records to PHIS.
- As part of the BC COVID-19 vaccination planned rollout, a digital solution for COVID-19 immunization has been implemented. This could be expanded to support the overall immunization program scheduling, data collection and reporting, including influenza immunization in the future.

Student Immunization Data and Reporting

- BC's Vaccination Status Reporting Regulation (the Regulation) came into force on July 1, 2019. The Regulation requires parents or guardians to provide public health officials with current immunization status records for school-age children (grades Kindergarten to Grade 12) in public and independent schools under provincial jurisdiction, including home-schooled students.
- To date, three provinces, including BC, have legislated immunization reporting policies for students. BC, Ontario, and New Brunswick require reporting of student immunizations for diseases with a high potential for causing outbreaks in school settings (e.g., measles).

Health Care Worker Influenza Control Program Policy

- The province-wide Influenza Control Program Policy was amended in December 2019[4] such that there is no longer any disciplinary action for health care workers required to receive the influenza vaccine or wear a mask in patient care areas. This has been replaced by a more collaborative approach to immunization.
- Health care workers are required to inform their employer if they have received an influenza shot.

Immunization Coverage Rates[5]

- In 2018, 74% of BC children are up-to-date for all routine infant and toddler immunizations by the time they turn 2 years of age[6].
- In 2019, 69% of 7-year-old children in BC are up-to-date for their preschool immunizations.[7]
- In 2019, human papillomavirus (HPV) program coverage for grade 6 females and males was 66.1% and 63.5%, respectively.[8]
- As of June 26, 2019, female age eligibility to receive publicly funded HPV vaccine was reduced from 'up to 26 years old' to 'up to 18 years old.'
- As of September 1, 2017, BC offers publicly funded HPV vaccine to grade 6 boys.
- As of September 1, 2016, BC improved its HPV vaccine program by replacing Gardasil-4 with Gardasil-9 (protects against 9 strains of HPV).

## FINANCIAL IMPLICATIONS

Government Financial Information

[4] CBC News. "B.C. nurses no longer need to get flu vaccine or wear masks, can rely on 'professional judgment'. Published December 4, 2019. https://www.cbc.ca/news/canada/british-columbia/b-c-nurses-no-longer-required-to-get-flu-vaccine-or-wear-mask-1.5384902

[5] BC Reports immunization coverage rates for children up to Two and Seven Years of age. Two-year old coverage rates do not include VCHA as they do not collect or report this information.

[6] BCCDC, p 5. Retrieved June 4, 2020 from Immunization Uptake in Children by the Second Birthday 2007-2018. Published April 4, 2019.

[7] BCCDC, p 5. Retrieved June 4, 2020 from Immunization Uptake in Children by the Seventh Birthday 2012-2019. Published November 6, 2019.

[8] BCCDC, p 10. Retrieved June 4, 2020 from Immunization Uptake in Grade 6 Students 2019. Published November 12, 2019.

[9] PHSA Finance, October 2019.

additional capacity for promoting influenza immunizations during the COVID-19 pandemic. The Ministry anticipates providing up to $500,000 to support promotion in 2021/22.

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**Approved:**
April 22, 2021 – Lorie Hrycuik, Executive Lead, Population and Public Health
April 27, 2021 – Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Shingles Vaccine

### TOPIC

Based on consistently high volumes of public letters and ongoing advocacy by seniors' groups,[1,2] there continues to be significant public interest in adding the shingles vaccine (Shingrix) to the publicly-funded provincial immunization schedule.

### CURRENT SITUATION

- BC does not have a publicly funded, province-wide immunization program for shingles at this time.
- BC's Communicable Disease Policy Advisory Committee has recommended adding a provincial immunization program for shingles that would use the Shingrix vaccine and target seniors 65 to 69 years of age.
- As part of BC's routine, annual review and evaluation process, all potential changes to the provincial immunization program – including possible expansion of the program to include Shingrix – are ultimately forwarded for Ministerial decision.
- In May 2019, the First Nations Health Authority announced that Indigenous seniors 65 to 69 years of age are eligible to receive reimbursement for the Shingrix vaccine in BC.
- Due to a supply shortage, the earliest BC could access the Shingrix vaccine for a provincial program would be 2024.[3]

### KEY FACTS

Shingles

- Shingles is caused by the varicella zoster virus, the same virus that causes chickenpox.
- Shingles manifests itself initially with itching or tingling of the skin, followed by a painful skin rash with blisters on one side of the body.
- Approximately 1 in 3 people in Canada will get shingles in their lifetime.[4]
- Approximately 1 in 5 people who get shingles continue to have severe pain (called post-herpetic neuralgia) after their rash clears up. This pain can last for more than 6 months after the rash clears.
- In rare circumstances, complications of shingles can include hearing problems, visual impairment, inflammation of the brain (encephalitis), and bacterial infection.
- There is no cure for shingles. Antiviral treatments are used when symptoms first appear to speed up healing and reduce pain.
- It is estimated 15% to 28% of people will develop shingles at some point in their life.
- People over the age of 65 are more likely to get shingles.
- When a person with shingles infects another person with the virus, that virus will cause chickenpox, not shingles. Chickenpox will only occur in people who have never had chickenpox or who have never been immunized against it.

Shingles Vaccines

*Zostavax*

- The first Shingles vaccine (Zostavax) was approved by Health Canada in 2008.
- Zostavax prevents shingles in about 50% of people who receive the vaccine.[5]
- Zostavax is a live vaccine that is not recommended for immune-compromised individuals.
- Zostavax costs $200 USD for a prescribed, single dose when purchased privately.[6]

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[1] CARP. "Our advocacy, vaccinations". https://www.carp.ca/vaccines/ accessed July 15, 2020.

[2] Vancouver Sun. "Seniors press B.C. government to cover cost of shingles vaccine". https://vancouversun.com/news/local-news/seniors-press-b-c-government-to-cover-cost-of-shingles-vaccine accessed July 15, 2020.

[3] BCCDC. [EMAIL] Sinclair, Jim; Vaccine Warehouse Manager, September 16, 2020.

[4] Brisson M, et al. "Epidemiology of varicella zoster virus infection in Canada and the United Kingdom". Epidemiology and Infection. 2011; 127. Pp. 305-14.

[5] HealthLink BC: https://www.healthlinkbc.ca/medications/zr1285; accessed October 10, 2019

[6] Reuters Health News. Shingles vaccine not cost effective before age 60; accessed October 10, 2019

*Shingrix*

- In October 2017, Health Canada approved a new shingles vaccine, Shingrix, which requires 2 doses, 2 to 6 months apart.[7]
- Shingrix is more than 90% effective at preventing shingles and post-herpetic neuralgia. Protection stays above 85% for at least the first 4 years after vaccination.[8]
- Shingrix can be given to those who are immune-compromised.

*Shingles Vaccine Coverage – Ontario*[9]

- In September 2016, the Government of Ontario announced publicly funding of Zostavax vaccine for adults aged 65 to 70.
- For those who qualify, shingles vaccine in Ontario is made available through family physicians, nurse practitioners and other primary care providers.[10]
- Ontario is the only Canadian jurisdiction offering a shingles vaccine program.[11]
- The Ontario government estimates the cost of funding this vaccine will be $68 million, based on approximately 850,000 eligible Ontario seniors.

*BC Human Rights Case*[12]

- A human rights tribunal case filed by Mr. Thomas Hasek against the Ministry of Health was heard in December 2017.
- Mr. Hasek claimed the Ministry's lack of coverage for the shingles vaccine was discriminatory based on age because the Province covers varicella (chickenpox) vaccine for children, but not shingles vaccine for seniors.
- On August 10, 2018, the BC Human Rights Tribunal dismissed the complaint in its entirety under s. 37(1) of the BC Human Rights Code.
- Mr. Hasek did not appeal the decision.

## FINANCIAL IMPLICATIONS

Government Financial Information

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**Approved:**

October 1, 2020 - Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division
January 28, 2021 - Lorie Hrycuik, Executive Lead, Population and Public Health Division
February 1, 2021 – Mitch Moneo, ADM, Pharmaceutical, Laboratory & Blood Services Division

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[7] GlaxoSmithKline. "GSK announces first approval of Shingrix in Canada". https://www.gsk.com/en-gb/media/press-releases/gsk-announces-first-approval-of-shingrix-in-canada accessed October 10, 2019.

[8] US Centers for Disease Control (CDC): https://www.cdc.gov/vaccines/vpd/shingles/public/shingrix/index.html; accessed October 10, 2019.

[9] Government of Ontario. "Ontario making shingles vaccine free for seniors". September 2016 https://news.ontario.ca/mohltc/en/2016/09/ontario-making-shingles-vaccine-free-for-seniors.html. Accessed October 10, 2019

[10] Government of Ontario. "Get the free shingles vaccine". https://www.ontario.ca/page/get-free-shingles-vaccine accessed July 15, 2020.

[11] Government of Canada. "Provincial and territorial routine vaccination programs for healthy, previously immunized adults". https://www.canada.ca/en/public-health/services/provincial-territorial-immunization-information/routine-vaccination-healthy-previously-immunized-adult.html. Accessed June 4, 2020.

[12] Hasek v. BC Ministry of Health (No. 2), 2018 BCHRT 187 (CanLII). http://canlii.ca/t/hthx7. Accessed October 10, 2019

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Legal Information

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Legal Information

# LEGISLATIVE SESSION - FACT SHEET

## Vaping Regulations

### TOPIC

To address the rise in youth vaping, new vaping regulations came into force on July 20, 2020 as part of the Provincial Vaping Action Plan.

### CURRENT SITUATION

- On July 20, 2020 the following new and amended regulations came into force:
  - E-substances Regulation (ESR);
  - amendments to the Health Hazards Regulation under the *Public Health Act; and*
  - amendments to the Tobacco and Vapour Products Control Regulation (TVPCR) under the *Tobacco and Vapour Products Control Act* (TVPCR).
- The regulatory changes include:
  - new restrictions on public advertising where youth can access, hear, or see advertisements.
  - prescribing non-therapeutic nicotine (as defined) as a health hazard,
  - a ban on sales of e-substances that do not contain nicotine or cannabis: these can entice youth into experimenting with e-substances and can lead to nicotine addiction,
  - a ban on the sales of products that contain both nicotine and cannabis,
  - regulating the sales of e-substances containing non-therapeutic nicotine; and,
  - requirements for all retailers to provide the Ministry of Health (the Ministry) with a notice of intent to sell e-substances, as well as product reports and manufacturing reports (if a retailer manufactures products at their retail location), with annual updates and specified reporting periods. As of April 23, 2021, the Ministry has received 2072 notices of intent from retailers.

Advice/Recommentations

- The Ministry has established a provincial reporting database to enable retailers to meet regulatory requirements under the ESR to submit their Notices of Intent and reports. Health authorities will have access to this database and information to facilitate enforcement.

### KEY FACTS

- On November 14, 2019, on behalf of the Province of BC, the Minister of Health, announced that BC would regulate vapour product access, flavours, nicotine content, packaging, and advertising as part of an action plan to address the rise in vaping and e-cigarette use by youth in BC.
- A *Vapour Products Intentions Paper*[1] was posted from December 17, 2019 to January 24, 2020 to solicit public and industry feedback on the proposed new regulatory measures. 686 responses were received from business owners, manufacturers of vapour products, retailers and retail associations, consumers of vapour products, educators, public health practitioners, and parents.
- A *What We Heard Report*[2] was published on March 24, 2020 summarizing feedback that assisted in informing the development of new regulations.

[1] Vapour Products Intentions Paper, Ministry of Health website, https://engage.gov.bc.ca/app/uploads/sites/121/2019/12/vapour-products-intentions-paper.pdf

[2] Public and Stakeholder Engagement, What We Heard Report, Ministry of Health webpage, https://www2.gov.bc.ca/assets/gov/health/vaping/vaping-products-what-we-heard-report.pdf

# LEGISLATIVE SESSION - FACT SHEET

- On April 19, 2021, the Federal Budget 2021 announced the government's intention to introduce a new taxation framework for the imposition of excise duties on vaping products in 2022[3]. Highlights of the new and amended regulations include:
  1. **Prescribing New Health Hazards -** the Health Hazards Regulation has been amended to prescribe a new health hazard:
     - Nicotine and nicotine salts (this does not include nicotine or nicotine salts categorized as Schedule I drugs under the Drug Schedules Regulation or expressly excepted as Schedule I drugs under the Drug Schedules Regulation ('Non-therapeutic nicotine').
     - Under the new E-Substances Regulation, the following are also considered health hazards:
       - E-substances that contain non-therapeutic nicotine; and,
       - E-substances that do not contain nicotine, nicotine salts or cannabis.
  2. **Limiting E-Substance Volume and Nicotine Content -** the E-Substances Regulation restricts the nicotine content in e-substances, requiring that:
     - The maximum nicotine concentration be no more than 20mg/mL;
     - The cartridges holding e-substances have a maximum capacity of no more than 2mLs; and,
     - The refill containers holding the e-substances have a maximum capacity of no more than 30mLs.
  3. **Restricting the Sale of Flavoured E-Substances:**
     - Stores accessible to minors (under 19 years of age), such as convenience stores, may only sell tobacco-flavoured e-substances.
     - Adult-only stores, such as speciality vape stores, may sell a wider range of flavoured e-substances except those prohibited by federal legislation. This includes flavours in the categories of desserts, cannabis flavour, confectionary, soft drinks, and energy drinks.
  4. **Provincial Labelling and Packaging Requirements – the E-Substances Regulation requires:**
     - Retailers to sell only those packages that state: i. The total volume of restricted e-substances; ii. The total concentration of nicotine; iii. A warning that nicotine is highly addictive; and iv. The hazard warning symbol.
     - Retailers must sell e-substances that are packaged with only the images and text prescribed, unless otherwise authorised by a federal enactment.
     - Retailers are permitted to sell a restricted e-substance in a package that states one or more of the following: the name and contact information of the manufacturer, the brand name and product name, and the type of product.
  5. **Mandatory Notice and Reporting -** The E-Substances Regulation requires business owners who sell restricted e-substances to provide the Ministry with:
     - A Notice of Intent (NOI) to sell at least 6 weeks before a restricted substance is first sold, followed by annual renewals of the NOI (prior to January 15 of each year they intend to continue sales).
     - Product reports (i.e. ingredients list and nicotine concentration) for each product sold, manufacturing reports (for retailers that also manufacture products for sale from their retail location), and annual sales reports (October 1 – September 20 of each year).
  6. **Restrictions on Public Advertising** – the following amendment has been made to TVPCR: Extension of existing prohibition of vapour product advertisements to any place where advertisements may be seen, accessed, or heard by youth. This includes public spaces such as malls, bus shelters, outside store fronts, billboards.
  7. **New Federal Labelling and Packaging -** the federal government's Vaping Products Labelling and Packaging Regulation came into force on July 1, 2020.
     - The E-Substances Regulation has been designed to work in tandem with the federal regulations.
     - Retailers can only sell restricted e-substances that are labelled and packaged following BC and federal legislation.

[3] Budget 2021 – A recovery plan for jobs, growth and resilience, https://www.budget.gc.ca/2021/pdf/budget-2021-en.pdf

# LEGISLATIVE SESSION - FACT SHEET

## FINANCIAL IMPLICATIONS

Government Financial Information

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**Approved:**

April 26, 2021 – Lorie Hrycuik, Executive Lead, Population and Public Health

April 26, 2021 - Gordon Cross obo Philip Twyford, ADM, Finance and Corporate Services Division

# LEGISLATIVE SESSION - FACT SHEET

## Youth Vaping

### TOPIC

Youth vaping (with and without nicotine) has increased substantially since 2017, introducing a new cohort of BC youth to potential harm including nicotine addiction and possible progression to tobacco smoking.

### CURRENT SITUATION

- Recent data shows rapid and unprecedented increases in vaping and e-cigarette use by youth in BC and across Canada. Vaping, with or without nicotine or other psychoactive substances, have known health impacts, especially for developing brains.
- On November 14, 2019, the Province launched a 10-point Youth Vaping Provincial Action Plan.
- The Action Plan focused on taking financial, regulatory and education and awareness measures to protect youth from the harms of vaping.
- A 20% provincial sales tax increase on all vaping products and accessories was brought into force on January 1, 2020.
- Regional youth tables were held (Ashcroft, Smithers, Vancouver, Langford and Sooke) engaging over 70 youth through January to inform a targeted social marketing campaign and enhancements to the BC Lung Vaping Prevention Toolkit.
- The social media campaign 'Evapourate' was successfully launched on February 14, 2020.
- On July 20, 2020 new and amended regulations came into force that:
    - regulated nicotine content in vapour products;
    - restricted the sale of flavoured vapour products;
    - implemented new labelling requirements to include plain packaging and health warnings;
    - strengthened restrictions on public advertising; and
    - enhanced compliance and enforcement of provincial laws.
- The BC Lung Association with support from the province created and distributed a youth vaping prevention toolkit to all K-12 schools in BC.
- QuitNow smoking cessation support services have been extended to support youth and others who want help to quit vaping. Further work is being done to customize the program to the needs of adult and youth vapers.
- Development of a Provincial Youth Advisory Council in partnership with the Ministry of Education (EDUC) and the McCreary Centre Society, intended to guide future actions launched on February 9th, 2021.
- Phase two of the 'Evapourate' campaign launched on February 11th, 2021.
- The McCreary Centre Society trained 28 young people from across BC as youth researchers to develop and deliver a 3-wave province wide survey of youth assessing the impact of the COVID-19 pandemic on their vaping behaviours. Over 3500 youth completed the vaping surveys issued in June, September, and December 2020 providing data and comments on their experiences and perceptions, along with insights on what is important to them to learn about vaping and their views on the role of schools in addressing youth vaping in BC.

### KEY FACTS

- The recently released 2020 *Youth and Young Adult Vaping Project* examined vaping behaviours, experiences, and product preferences of youth and young adult e-cigarette users in Canada and found:
    - Nine in ten (92%) young people cite flavours as an important reason why they started vaping and the same number (90%) say it is an important factor for continuing to do so with their most preferred flavours being berry, confectionary, mango and mint/menthol.
    - Nine in ten (92%) of the youth vapers surveyed use e-juice that contains nicotine and of these almost all (98%) are aware of the nicotine concentration in their devices.
    - Two-thirds (66%) of young people who use vapes use the highest concentrations of nicotine available; between 50–60mg/ml.

  - Vaping is affordable for young people. Cigarette taxes range from 60% to 76% of the purchase price across provinces, while vaping product taxes range from 5% to 38%.
  - Virtually all young vapers (99%) have been offered someone else's vape to use and almost the same amount (93%) have offered to share their own.
  - Over one-quarter of youth surveyed indicated they began smoking cigarettes after they started vaping and over one-third know someone who began smoking after they started vaping. Only 17% report using vapes as a smoking cessation strategy.
- In 2018, 21% of BC in school youth (Grades 7-12) in the past month had vaped with nicotine, and 19% without nicotine. This results in a combined rate of 27% who had vaped, with or without nicotine. As well, 7% reported they had used cigarettes, 3% used cigars/cigarillos, 2% used chewing tobacco, and 2% had used a hookah. Two percent reported using a product to help stop smoking.[1]
- Based on national 2018-19 data, BC youth e-cigarette rates (past 30-day use) were 27.6%, compared with 20.2% nationally. The BC rate is the fourth highest in Canada.[2]
- Enforcement is provided by health authority enforcement officers through Public Health Departments and is typically delivered based on risk management models established by each health authority which guides the frequency of inspections.
- The E-Substances Regulation requires all businesses that sell vapour products to submit a Notice of Intent to sell which will create a location database of all retail locations in BC.

## FINANCIAL IMPLICATIONS

Government Financial Information

**Approved:**
April 23, 2021 – Lorie Hrycuik, Executive Lead, Population & Public Health
April 23, 2021 – Peter Klotz A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Division

[1] Balance and Connection: BC Adolescent Health Survey (2018). McCreary Centre Society (Vancouver) Pages 46-48 Downloaded from https://mcs.bc.ca/about_bcahs; See also: Filtering through the haze: Tobacco use and vaping among BC youth, McCreary Centre Society (in press).

[2] Detailed tables for the Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS) 2018-2019, accessed June 5, 2020 from https://www.canada.ca/en/health-canada/services/canadian-student-tobacco-alcohol-drugs-survey/2018-2019-detailed-tables.html

# FACT SHEET

# Traditional Chinese Medicine and Acupuncture in BC

## TOPIC

- The practice of Traditional Chinese Medicine (TCM) means the promotion, maintenance and restoration of health and prevention of a disorder, imbalance or disease based on traditional Chinese medicine theory, by utilization of the primary therapies of:
    - Chinese acupuncture (Zhen), moxibustion (Jiu) and suction cup (Ba Guan);
    - Chinese manipulative therapy (Tui Na);
    - Chinese energy control therapy (Qi Gong);
    - Chinese rehabilitation exercises such as Chinese shadow boxing (Tai Ji Quan); and
    - Prescribing, compounding or dispensing Chinese herbal formulae (Zhong Yao Chu Fang) and Chinese food cure recipes (Shi Liao).

## CURRENT SITUATION

- Current issues related to TCM and acupuncture, regarding the discontinuation of examinations in Chinese and the request to amend scope of practice, are addressed under a separate fact sheet titled Traditional Chinese Medicine and Acupuncture: Exams and Scope of Practice.

## KEY FACTS

- The College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia (CTCMA) is the regulatory body established for the health professions of traditional Chinese medicine (TCM) and acupuncture.
- Acupuncture has been a designated health profession under the *Health Professions Act* (HPA) since April 1, 1996.
- TCM has been a designated health profession under the HPA since December 4, 2000.
- Before designation under the *Health Professions Act*, these professions were unregulated in British Columbia.
- The TCM and acupuncture professions are regulated by the CTCMA in accordance with the Act, the Traditional Chinese Medicine Practitioners and Acupuncturists Regulation (which sets out scope of practice) and the bylaws of the CTCMA.
- The CTCMA is one of eight regulatory colleges whose regulations have not yet been updated to fully align with the HPA's Shared Scope of Practice/Restricted Activities Model. (For more information on TCM practitioner and acupuncturist scope of practice see the fact sheet titled Traditional Chinese Medicine and Acupuncture: Exams and Scope of Practice.)
- There are currently 1,911 registrants across the four reserved titles of acupuncturist, doctor of traditional Chinese medicine, traditional Chinese medicine herbalist, and traditional Chinese medicine practitioner[1].
- Kwantlen Polytechnic University (KPU) offers a TCM Acupuncture diploma program, which operates without funding from government. KPU has signed a general Memorandum of Understanding with Beijing University of Chinese Medicine.
- In addition to KPU, there are seven[2] private institutions in BC that offer CTCMA-recognized TCM education programs, which are acceptable to the Private Training Institutions Branch of the Ministry of Advanced Education, Skills and Training. Two of the 8 private institutions offer programs in Chinese. (For more information on the provision of examinations in Chinese see the fact sheet titled Traditional Chinese Medicine and Acupuncture: Exams and Scope of Practice.)

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[1] CTCMA 2019-20208 Annual Report, retrieved 2021-03-04 from https://www.ctcma.bc.ca/media/1928/annual-report-2019-2020.pdf

[2] CTCMA bylaws Schedule H retrieved 2021-03-09 from https://www.ctcma.bc.ca/media/1942/ctcma-bylaws-and-schedules.pdf

# FACT SHEET

- The number of CTCMA registered practitioners has been gradually increasing each year, and the number of CTCMA registered students has remained fairly static at approximately 400+ per year.

| CTCMA Registrant Classes | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Registration Type** | **2015-2016** | | **2016-2017** | | **2017-2018** | | **2018-2019** | | **2019-2020** | |
| Doctor of TCM | 317 | 14.8% | 310 | 13.7% | 324 | 14.0% | 325 | 14.0% | 343 | 13.8% |
| TCM Practitioner | 454 | 21.1% | 498 | 22.0% | 532 | 22.9% | 567 | 24.0% | 580 | 23.3% |
| Acupuncturist | 806 | 37.5% | 846 | 37.5% | 878 | 37.8% | 917 | 38.8% | 959 | 38.5% |
| Herbalist | 33 | 1.5% | 31 | 1.4% | 31 | 1.3% | 31 | 1.3% | 29 | 1.2% |
| Student | 434 | 20.2% | 456 | 20.2% | 447 | 19.3% | 427 | 18.1% | 491 | 19.7% |
| Non-practicing | 103 | 4.8% | 118 | 5.2% | 110 | 4.7% | 110 | 4.7% | 87 | 3.5% |
| **Total practicing** | **2,044** | **95.2%** | **2,141** | **94.8%** | **2,212** | **95.3%** | **2,267** | **95.3%** | **2,402** | **96.5%** |

Source: CTCMA 2019-2020 Annual Report (data for years 2017-2018 to 2019-2020), and the CTCMA (data for years 2015-2016 to 2016-2017).

## FINANCIAL IMPLICATIONS

- For Medical Services Plan (MSP) beneficiaries receiving premium assistance, the MSP contributes $23 per visit for a combined annual limit of 10 visits each calendar year for the following: acupuncture, chiropractic, massage therapy, naturopathy, physical therapy and non-surgical podiatry.
- Acupuncture services were included among the benefits of the Supplementary Benefits program effective April 1, 2008.
- Payments for acupuncture for 20192019/20 were $4.4 million4million (paid for 2828,235 patients or 191126,269 services).[3]

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**Approved by:**

April 24, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
April 30, 202130 – Peter Klotz, A/CFO obo Philip Twyford, ADM and EFO, Finance & Corporate Services Division
April 29, 2021 – Eric Larson obo Martin Wright, ADM, Health Sector Information, Analysis and Reporting Divisio

[3] Per HSIAR report for supplementary benefits at September 30, 2020 cut-off.[3] Health Sector Information Analysis and Reporting Division, Ministry of Health, Supplementary Monthly Report – March 31, 2021 (Specialty 68)

# LEGISLATIVE SESSION - FACT SHEET

## Chiropractic Issues in BC

### TOPIC

There has been attention in the media on the chiropractic profession and the College of Chiropractors of BC (CCBC) in response to the promotion and marketing of several controversial health statements/claims by some chiropractors (e.g. anti-vaccination statements, treatments for COVID-19, etc.) and relating to the conduct of some registrants.

### CURRENT SITUATION

- The CCBC continues to provide guidance to registrants relating to marketing activities and address issues where identified (including referring matters to its Inquiry Committee).
- Recently, materials that have raised media attention include unsupported claims related to COVID-19, spinal radiography, such as use of X-rays and claims that chiropractic can boost the immune system, treat Attention Deficient Hyperactivity Disorder and treat ear infections.
- In September 2020, media attention was also focused on marketing materials found on the social media of a CCBC board member. The board member resigned in September 2020. The CCBC is determining why the materials slipped past its online Marketing Review Tool.
- There has also been recent media attention regarding complaints raised against a CCBC registrant who was alleged to be in breach of provincial orders to wear a mask indoors in a clinical setting.

### KEY FACTS

- The chiropractic profession was brought under the *Health Professions Act* (HPA) on March 1, 2009. It had previously been regulated under the former *Chiropractors Act* since 1934. The 2019/20 CCBC annual report states there are 1349 active registrants in BC.
- Registrants of the CCBC must graduate from a recognized chiropractic education program (4-year Doctor of Chiropractic degree) and have written the Canadian Chiropractic Examining Board exams. The 2 recognized Canadian Chiropractic schools are in Ontario and Quebec.
- The Chiropractors Regulation indicates "chiropractic" means the health profession in which a person provides, for the purposes of promotion, maintenance and restoration of health, the services of:
  a) assessment of the spine or other joints of the body and the associated tissue, and the nervous system;
  b) treatment of nervous system, muscular and skeletal diseases, disorders and conditions through manipulation or adjustment of the spine or other joints of the body by hand or by using devices directly related to the manipulation or adjustment, and
  c) advice and counseling on matters related to the condition of the spine or other joints of the body and the associated tissue, the nervous system and the overall health of the individual.
- Chiropractors and the CCBC continue to face ongoing scrutiny in the media, from medical practitioners and health watchdog groups, related to promotion on social media of practices such as anti-vaccination and other claims to prevent and treat diseases/conditions through chiropractic treatment. Some of these treatments and claims are outside of the chiropractic scope of practice and have limited evidence to support their usage.
- Chiropractors are not trained in preventing infectious disease. Therefore, CCBC prohibits registrants from giving advice about immunization, as it falls outside their scope of practice.
- After receiving multiple complaints about chiropractors providing immunization advice, in May 2018, the CCBC issued a Special Notice reminding all registrants that they could only provide services within the chiropractic scope of practice, as set out under the HPA and the Chiropractic Regulation. Registrants were advised to remove content from their websites and social media platforms that did not comply with CCBC Professional Conduct and Standards.
- In mid 2018, CCBC implemented an electronic marketing review tool to review registrants' online marketing materials to ensure compliance with the marketing policy. The tool is currently used to scan a range of registrants' online content including social media posts and other web content.
- On October 3, 2018, the CCBC sent their Efficacy Claims Policy to registrants, which reinforced its support of evidence-informed healthcare and that misleading and unsubstantiated claims about the efficacy of treatment made by chiropractors are unacceptable. On November 16, 2018, the CCBC reported that 50 B.C. chiropractors were non-compliant with the Efficacy Claims Policy. All are now compliant and continue to be monitored for compliance.

- In June 20, 2019, the CCBC suspended a registrant for marketing and providing 'brain balancing' services, which fall outside the chiropractic SOP.
- In July 2019, the CCBC ordered a significant review of the evidence and regulatory approaches related to spinal manipulative therapy (SMT) and children. On September 30, 2019 the CCBC released a public notice stating they had concluded this review. After considering the available evidence, including an independent research review, the CCBC determined that the use of SMT in children did not present a significant risk of harm to the public.
- On December 23, 2019 the CCBC made amendments to the Efficacy Claim Policy regarding pregnancy related conditions. Registrants were required to comply by January 30, 2020. Approximately 100 registrant websites were found to have possible issues which were addressed by the compliance date.

**COVID-19 related marketing**

- In March 2020, three registrants made claims related to boosting the immune system through chiropractic services that included inappropriate marketing around COVID-19. CCBC contacted the registrants immediately and instructed them to cease these communications.
- On March 13, 2020 – CCBC issued a notice to registrants and posted it on their website to convey expectations around marketing, specific to COVID-19. On March 16, 2020, CCBC was notified of a registrant's video posted on social media claiming cold showers boost immunity. COVID-19 was mentioned in the video. The registrant was contacted the same day and removed the video immediately.
- In early March 2020, COVID-19 related terms were added to the marketing review tool used by CCBC to monitor web and social media of registrants. On March 18, CCBC identified 93 mentions of 'immune boosting' that were determined to be possibly against the rules. Registrants were instructed to remove the materials. Compliance was immediate for all but eight registrants. Investigations were initiated and materials removed, with the Inquiry Committee pursuing consent agreements and fines for all matters.
- In December 2020, the CCBC received a complaint which drew media attention regarding a CCBC registrant who was alleged to not be wearing a mask indoors in a clinical setting in breach of provincial orders. The registrant provided a letter from an MD advising that she is exempt from wearing a mask and signed an undertaking with the CCBC requiring her to advise all patients that she is not able to wear a mask and that patients, and anyone with them, must wear a mask while they are in the office.

**Other recent marketing issues**

- In early March 2020, a multi-disciplinary clinic employing chiropractors, issued a news release on a new holistic infant care program. The CCBC contacted the chiropractic registrants on March 11 and the news release was removed. An investigation was initiated on March 16 which included all materials on the clinic website. All materials of concern were immediately removed by the registrants.
- On July 15, 2020, CCBC announced on its website that due to the results of a research review they requested on the use of routine and repeat spinal radiography, such as X-rays, they would be amending the Professional Conduct Handbook (PCH). The review found no evidence that the routine/repeat use of X-rays to assess spine function or structure (in the absence of clinical suspicion of a serious pathology) improves clinical outcomes.
- On August 11, 2020, the CCBC posted on their website the draft amendments to the PCH on the use of X-rays. Over 1,000 responses were received by the deadline of September 8, 2020, many concerned about the elimination of chiropractors' ability to use radiography. The CCBC clarified on their website that they have no intention to eliminate the use of radiography, and that the purpose of the review is to analyse the clinical utility of routine and repeat spinal radiographs with the proposed aim of limiting its use to "red flag" cases.
- In September 2020, a complaint was made about the Facebook materials of a board member. The CCBC inquiry committee is currently investigating the complaint and reviewing why the content was missed by its online Marketing Review Tool. The board member has since resigned.
- The CCBC continues to regularly update the Ministry on advertising compliance, efficacy claims and other regulatory matters as they relate to the health and safety of the public. The CCBC continues to closely monitor registrant marketing for compliance using a Marketing Review Tool and by monitoring social media posts daily.

## FINANCIAL IMPLICATIONS

- N/A

**Approved:**

February 11, 2021 – Mark Armitage, ADM, Health Sector Workforce and Beneficiary Services Division
February 12, 2021 – Peter Klotz, A/CFO obo Philip Twyford, ADM, Finance and Corporate Services Branch

# LEGISLATIVE SESSION - FACT SHEET

**To provide information on the reclamation of traditional Indigenous names**

## TOPIC

- In 2015 the Truth and Reconciliation Commission of Canada (TRC) published 94 Calls to Action. Call to Action #17 has implications to the Vital Statistics Agency.

- Call to Action # 17 (TRC 17)
  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.

## CURRENT SITUATION

- Vital Statistics Agency (VSA) has been processing reclamation of indigenous names since the announcement of TRC 17.
- To date, a limited number of individuals have come forward requesting a name change.
- The current legislation under the *Name Act* does not allow for the issuance of mononyms (single names); a request for legislation has been put forward to address this issue.
- While the VSA currently only uses characters from the Anglo-Franco character set, there may be a demand for unique first nations symbols and characters.

Advice/Recommentations

- The VSA has been consulting with ICBC and BC Services Card representatives to ensure fees are waived for the reclamation of an indigenous name.

## KEY FACTS

- Individuals wishing to reclaim their indigenous identity in British Columbia simply need to contact the VSA.
- The VSA will assist the individual in establishing that individual's name from past records to the extent it can.
- The VSA will provide a letter for the individual to indicate that the name change occurred under TRC Call to Action #17, which they may use as they approach down stream agencies and organizations.

## FINANCIAL IMPLICATIONS

- No impact for the VSA other than waiving the $137 to process the change of name.
- There are additional fees from other agencies (fingerprinting) that the Vital Statistics Agency cannot waive.

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**Approved:**
16 June 2021 - Martin Wright, Health Sector Information, Analysis and Reporting