

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:33 PM
To: Dhanowa, Damon HLTH:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX
Subject: Re: POG

Sounds about right.

Laura would you mind clarifying for NW?

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 7:29 PM
To: Scheffel, Emile HLTH:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX
Subject: Re: POG

I think the error is he doesn't say the spray will save a life he is talking about the drug itself being administered.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:28 PM
To: Dhanowa, Damon HLTH:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX
Subject: Re: POG

Thanks for checking!

Looks like this:

CKNW (Vancouver)

12-Jan-2016 19:03

Copyright

TNO...

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:28 PM
To: Robertson, Derek HLTH:EX
Subject: Re: New submission from Contact Your Constituency

Perfect thx

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 7:26 PM
To: Scheffel, Emile HLTH:EX
Subject: Re: New submission from Contact Your Constituency

Yep

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:24 PM
To: Robertson, Derek HLTH:EX
Subject: Re: New submission from Contact Your Constituency

Hey did this go to staff?

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 7:10 AM
To: Morris, Kirsty L LASS:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Re: New submission from Contact Your Constituency

Thanks Kirsty, and Good Morning :)

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

From: Morris, Kirsty L
Sent: Tuesday, January 12, 2016 7:08 AM
To: Robertson, Derek HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Fwd: New submission from Contact Your Constituency

Sent from my iPhone

Begin forwarded message:

From: s.22
Date: January 12, 2016 at 1:02:26 AM PST
To: "Morris, Kirsty L" <Kirsty.Morris@leg.bc.ca>
Subject: Re: New submission from Contact Your Constituency

Well another 60km trip to the pharmacy, and was told that pharmacare would not cover the stop smoking aids as I have

s.22

s.22

I now think I should be billing BC Medical for the 120 km that I have wasted since they can not get their act together. I want something done about this ASAP. I have no choice but to contact the media if I do not hear back from MSP within 3 days. My home phone number is s.22
s.22 and Cell number is s.22

On Mon, Jan 11, 2016 at 10:05 AM, Morris, Kirsty L <Kirsty.Morris@leg.bc.ca> wrote:

s.22

Dear

Thank you for your email to MLA Terry Lake. I am sorry to hear that you experienced some difficulties re accessing the new smoking cessation program. I have forwarded your email through to the Ministry of Health for their response to your concerns.

Regards

Kirsty

Kirsty L Morris | Constituency Assistant

*Terry Lake, MLA Kamloops - North Thompson
Minister of Health*

Email: kirsty.morris@leg.bc.ca
Phone #: [250-554-5413](tel:250-554-5413) Fax #: [250-554-5417](tel:250-554-5417)

From: s.22
Sent: January 7, 2016 12:17 AM
To: Lake.MLA, Terry <Terry.Lake.MLA@leg.bc.ca>
Subject: New submission from Contact Your Constituency

Name
s.22

Email
s.22

Riding

Kamloops – North Thompson

Comments & Feedback

Re: New Smoking Cessation Aid

I went to my pharmacy as was stated on the news, pharmacy was great and went right to work, filling out the paper work for both me and my husband, he got his no problem. but for myself pharmacare said that since

s.22 It took me 3 phone calls, and 1 1/2 hrs on the phone to straighten it out. I have been paying MSP for 25 years and it took all that, in order for me to get the aid to quit smoking. If the government is going to cover the full cost as they are saying, why are they trying to have peoples extended health care, or other service providers pay for it. Either they cover it or they do not.s.22 it will now cost me another 60 km trip to get the aids. I can little afford this as s.22
s.22 , so I live on a very limited budget, gas is expensive due to living in a rural village, an especially since 7.5 cents per litre was added. Yes there is a bus here that will take us into town, but I can not sit around for 3 hrs. before you can catch one back. Due to distances we have no option but to drive here, the same for many other rural communities, this needs to be addressed by your government, there should be a gasoline rebate. We in rural BC have no choice but to drive.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:04 PM
To: Dhanowa, Damon HLTH:EX; Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: Re: Quote Approval - Post-secondary students learn about a healthier drinking culture

FYI Minister, GCPE is talking to AVED about a potential event.

Thanks E

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 10:34 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: Quote Approval - Post-secondary students learn about a healthier drinking culture

Good morning Minister – This NR is for release tomorrow afternoon after caucus releases go in the am. Thanks :Ds.17

“As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning,” said Lake. “Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person’s life can help set them on the right track.”

Post-secondary students learn about a healthier drinking culture

VICTORIA – Students at B.C. public post-secondary institutions will have access to additional supports to address substance use thanks to a \$400,000 investment for a project co-led by the Centre for Addictions Research of BC and the Canadian Mental Health Association BC Division, Health Minister Terry Lake announced today.

According to the 2013 National College Health Assessment Canadian survey, 26% of post-secondary students reported that the last time they socialized, they had seven or more drinks and 39% of students who drank alcohol in the last year said they later regretted something they did when drinking.

“As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning,” said Lake. “Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person’s life can help set them on the right track.”

Changing the Culture of Substance Use is a project currently being implemented at 11 public post-secondary institutions throughout British Columbia. Changing the culture of alcohol and substance use is a long-term process that requires engagement from several levels of society, including communities, organizations, campus administration and individuals.

“Post-secondary students need to make informed choices on the use of alcohol,” said Advanced Education Minister Andrew Wilkinson. “Facilitating a conversation on the use of alcohol is a good way to ensure that students have the full facts.”

Project researchers are working with public post-secondary institutions to create a wider range of resources and strategies, which will engage key groups such as student leaders, students in residence and those in their first year.

“The Centre for Addictions Research of BC at the University of Victoria is pleased to continue its partnership with the Ministry of Health to ensure available evidence is utilized in real-world applications that improve the health of British

to prepare and enjoy a meal together on a regular basis, and to talk about substance use on campus and how the culture can be changed.

“As someone who is going on their fourth year living in this residence, I have noticed a big change in how people drink and party in residence,” said Hailee-Jean Lindgren, a student at Thompson Rivers University in Kamloops. “In my first year, there were stories of residence advisors needing to stay up all hours because parties kept being moved throughout the night. In my third year, when Drink with Class was first introduced, it turned around so that residents were willingly telling resident assistants about parties and asking for help in keeping those parties under control.”

Campus-community partnerships are also being developed to help promote healthier relationships with alcohol among students. Recognizing that campuses exist within the context of a larger community, the partnerships will work with partners such as bars, pubs and transportation systems.

“The Canadian Mental Health Association BC Division appreciates the continued investments in student mental health and well-being by the Ministry of Health,” said Bev Gutray, CEO at CMHA BC. “The Changing the Culture of Substance Use project is an integral part of our work promoting student mental health across British Columbia, through Healthy Minds, Healthy Campuses. With continued government investment, and in partnership with CARBC, we have built a strong and active network of BC campuses focused on ensuring the conditions are in place to increase participation in, and completion of, post-secondary education for all students.”

This investment aligns with the provincial government's 10-year mental-health and substance use plan, Healthy Minds, Healthy People, which focuses on prevention, early intervention, treatment and sustainability of mental health and substance use supports. The announcement meets a commitment within the plan to provide more substance use initiatives across the province.

The Province also offers Alcohol Sense, a comprehensive suite of online resources aimed at providing parents with tools to guide and educate their children to make healthy decisions about alcohol through critical thinking and conversation.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 6:45 PM
To: Lake, Terry HLTH:EX
Subject: Re: ADTI

Will set it up.

Original Message
From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:44 PM
To: Scheffel, Emile HLTH:EX
Subject: ADTI

There is a decision note on this but I should get a briefing first.

Terry Lake DVM
Minister of Health

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 6:39 PM
To: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Fw: 1042868 - PCQRB Recommendation re Treatment of Low Acuity Patients in ERs.pdf
Attachments: 1042868 - PCQRB Recommendation re Treatment of Low Acuity Patients in ERs.pdf

Aaaaand one more

Original Message

From: Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca>
Sent: Tuesday, January 12, 2016 6:37 PM
To: Scheffel, Emile HLTH:EX
Subject: 1042868 - PCQRB Recommendation re Treatment of Low Acuity Patients in ERs.pdf

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 1042868

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

TITLE: Patient Care Quality Review Board Recommendation Regarding Treatment of Low Acuity Patients in Emergency Departments

PURPOSE: To obtain a decision on the Ministry's response to a Patient Care Quality Review Board recommendation to dissuade patient use of Emergency Departments for low acuity ailments (Board File 14-100).

BACKGROUND:

- On July 17, 2015, the Fraser Patient Care Quality Review Board (the Board) completed its review of a complaint made on behalf of^{s.22}
- s.22

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- s.22

s.22

Following its review, the Board made the following recommendation to the Minister of Health: *That the Minister review this case to determine how best to ensure effective and efficient delivery of quality patient care for low acuity problems such as the epistaxis issue involved here, including by: a) enhanced public education about when to use ED facilities and when not to; b) enhanced information services for the availability of physicians and clinics to deal with low acuity problems; c) training programs and protocols for ED physicians and staff at the time of initial presentation at ED facilities by low acuity patients so as to encourage referrals to physicians or clinic services outside of the ED and without taking up ED time and resources.*

DISCUSSION:

- Reducing unnecessary ED visits and improving ED patient flow are existing Ministry priorities outlined in the 2014 document *Setting Priorities for the B.C. Health System* (pg. 25).
- Parts (a) and (b) of the Review Board's recommendation are already well addressed by provincial health information resources. Regardless of their health status, patients can access:
 - 8-1-1, a free provincial health information phone line where patients can speak with a nurse and get advice on whether to seek care at a local ED.
 - The HealthLink BC website, which provides detailed information about how and where to find health services in B.C.
 - The HealthLink BC "FIND Services" tool, which provides online mapping of urgent care and walk-in clinics, as well as navigation assistance for locating nearby health resources.

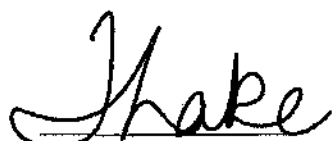
- The HealthLink BC "Smart Decisions" tool, which guides patients through key health care decisions by combining medical information with their personal values.
- Research indicates that public awareness campaigns regarding the use of emergency medical services have limited effect, as changes in public behaviour are not maintained beyond the end of the campaign itself¹. Sustained information resources, such as those outlined above, are strongly preferred to short term information campaigns.
- Part (c) of the Review Board's recommendation is not consistent with established clinical practices or professional accountabilities relating to patients seeking treatment in EDs:
 - ED staff assume responsibility for a patient once triage is complete. According to the Canadian Medical Association *Code of Ethics*, once responsibility for a patient is assumed, services must continue to be provided until they are no longer required or until another physician has taken responsibility.
 - ED staff cannot ensure a patient's safety if they advise them to seek treatment elsewhere. Conditions that present as low acuity may develop into significant concerns requiring immediate and comprehensive care that cannot be provide outside of a hospital setting.
- The Review Board does not offer strong evidence that treatment of epistaxis in EDs represents a significant provincial concern to the extent that a clinician training program would produce an exceptional return on investment:
 - s.22
- The Review Board found there were 2,238 cases of epistaxis treated at EDs in FHA between November 1, 2013 and October 31, 2014. However, presentations for epistaxis during this period accounted for only 0.4% of total ED visits across BC (see Appendix A).

OPTIONS (see Appendix B for Pros and Cons)

1. **Do Not Accept the Recommendation** – Inform the Board the Ministry will not implement the recommendation.
2. **Accept the Recommendation in Part** – Inform the Board that the Ministry will continue to address parts (a) and (b) of the recommendation through public information resources and initiatives relating to Emergency Department services, but will not implement part (c).

FINANCIAL IMPLICATIONS: No additional funds required for the recommended option.

RECOMMENDATION: Option 2.



Approved/Not Approved
Terry Lake
Minister of Health

Jan. 11, 2016

Date Signed

Program ADM/Division: Doug Hughes, ADM, Health Services Policy Division
Telephone: (250) 952-1049
Program Contact (for content): Brian Sagar, Director, Patient Safety & Care Quality

¹ Hodgson, et al. *Can Mass Media Influence Emergency Department Visits for Stroke?* Stroke. 107 – 1. Published online May 3, 2007

**Appendix A: Treatment Volumes for Epistaxis in BC Emergency Departments
(November 1, 2013 – October 31, 2014)**

Health Authority	Total ED Visits	Epistaxis Cases (as Presenting Complaint or Discharge Diagnosis)	Epistaxis as % of Total ED Visits
FHA	640,146	2,238	0.35%
IHA (KGH, RIH, PRH)	166,796	867	0.50%
NHA (UHNBC)	43,578	151	0.35%
PHSA (C&W)	43,458	154	0.35%
VCHA	328,061	1,336	0.40%
VIHA	-	Data unavailable	Data unavailable
Provincial Total	1,222,039	4,746	0.4%

Page 0012

Withheld pursuant to/removed as

s.13

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 6:34 PM
To: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Fw: 1042318 - Nursing Regulations.pdf
Attachments: 1042318 - Nursing Regulations.pdf

One more thx

Original Message

From: Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca>
Sent: Tuesday, January 12, 2016 6:33 PM
To: Scheffel, Emile HLTH:EX
Subject: 1042318 - Nursing Regulations.pdf

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 6:32 PM
To: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Fw: 1045663 - Launch of Carrot Rewards - DBN.pdf
Attachments: 1045663 - Launch of Carrot Rewards - DBN.pdf

Signed -- could you please return to staff?

Thanks E

Original Message

From: Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca>
Sent: Tuesday, January 12, 2016 6:30 PM
To: Scheffel, Emile HLTH:EX
Subject: 1045663 - Launch of Carrot Rewards - DBN.pdf

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 1042318

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

TITLE: Nursing Regulations

PURPOSE: To amend the nursing regulations which include the Nurses (Registered) and Nurse Practitioner Regulation, the Nurses (Registered Psychiatric) Regulation, the Nurses (Licensed Practical) Regulation, in accordance with the *Health Professions Act* (HPA) and the Prescribed Health Care Professions Regulation in accordance with the *Pharmacy Operations and Drug Scheduling Act*.

BACKGROUND:

BC has implemented the shared scope of practice/restricted activities regulatory model for self-regulating health professions. Nursing regulations required amendments in order to fully transition under the model and provide clarity regarding the scope of practice and restricted activities of the various types of nursing professions.

After receiving Minister approval, the proposed amendments were posted on the Ministry of Health (the Ministry) and college websites for a 90-day consultation period from April 9, 2015 to July 9, 2015 ^{s.13}
s.13

During the consultation period, a variety of stakeholders offered input including the three nursing regulatory colleges, the Chief Nursing Officer Council (CNO), the BC Coalition of Nursing Associations, BC Nurses Union (BCNU) as well as from a number of individuals. The CNO includes representatives of each of the health authorities, and the BC Coalition of Nursing Associations represented all of the nursing associations. ^{s.13}
s.13

^{s.13} Follow up with the Colleges, the Associations, the Doctors of BC, the union and the health authorities will be done to coordinate consistent implementation.

DISCUSSION:

The feedback from the consultation period falls into three categories.

1. Comments indicating administrative errors, unintentional omissions and recommendations for accurately reflecting current scopes of practice. These comments have been addressed in the final version of the regulations. It is unlikely that these changes will cause concern amongst stakeholders. Examples include:
 - adding the definition of 'issue' from the RN regulation to both the RPN and LPN regulation for consistency and clarity;
 - removal of "for the purpose of oral pharyngeal suctioning" from the description of a restricted activity as this is anatomically inaccurate;

- re-inserting the ability for LPNs to deliver services for immunization programs without an order. This was originally included, but inadvertently deleted;
- enabling RPNs to administer authorized drugs by any method, including intravenously. "Intravenously" was excluded in the previous draft, but its addition reflects current practice.

s.13

3. Comments that do not affect the language of the regulation, but may be relevant to implementation by employers or regulators. These comments will be shared with the CNOs and nursing colleges.

Enclosed:

Appendix A – Includes the Nurses (Registered) and Nurse Practitioner Regulation Ministerial Order, yellow tag, schedule, redline and regulation criteria checklist.

Appendix B – Includes the Nurses (Registered Psychiatric) Regulation Ministerial Order, yellow tag, schedule, redline and regulation criteria checklist.

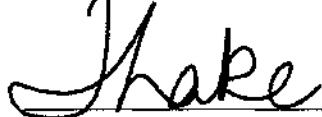
Appendix C – Includes the Nurses (Licensed Practical) Regulation Ministerial Order, yellow tag, schedule, redline and regulation criteria checklist.

Appendix D – Includes the Prescribed Health Care Professions Regulation Ministerial Order, green tag, redline and regulation criteria checklist.

FINANCIAL IMPLICATIONS: N/A

IMPACT ON REGULATORY COUNT: NONE

RECOMMENDATION: The Minister signs this Order as drafted.



Approved/Not Approved
Honourable Terry Lake, Minister of Health
Minister of Health

Jan 11, 2016
Date Signed

Program ADM/Division: Ted Patterson, ADM, Health Sector Workforce Division

Telephone: 250-952-3465

Program Contact (for content): Brian Westgate, Professional Regulation and Oversight

Drafter: Ranique Sekhon, Senior Policy Analyst, Professional Regulation and Oversight

Date: December 23, 2015

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 1045663

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

TITLE: Launch of Carrot Rewards

PURPOSE: To support a public launch of the Carrot Rewards national healthy living platform.

BACKGROUND:

The Ministry of Health (the Ministry), in partnership with the Public Health Agency of Canada (PHAC) and Social Change Rewards (SCR), is preparing to support the official launch of the innovative healthy living platform called Carrot Rewards. The partners are poised to have all elements in place to enable a public launch of Carrot Rewards in early 2016. The preferred approach is to have the Minister of Health participate in a public event or announcement of the release of Carrot Rewards, pending his interest and availability for the proposed timeframe.

Carrot Rewards will be available exclusively to British Columbians for a period of three months from date of launch. Confirmed points providers for the launch include SCENE, Aeroplan, Overwaitea, and Petro Points. SCR continues to negotiate with other potential point providers and the roster for that will continue to be of interest to the Ministry as the app grows in usage.

The Ministry, PHAC and SCR are working together to ensure that all elements are in place for a secure and successful launch. A central component of marketing Carrot Rewards will be through the opt-in databases that the point providers have, connecting to upwards of 850,000 British Columbian email addresses. The email promotion from each point provider will offer an incentive from their loyalty program for downloading the app. That email will also recognize the government partners and the national NGO partners (YMCA Canada, Heart & Stroke Foundation and the Canadian Diabetes Association). Extensive forecast modeling is in place to monitor engagement of this first invitation to British Columbians.

In preparation for the launch, SCR has hired a third-party privacy consultant to review privacy practices. This builds off the guidance provided by the Ministry's Health Information Privacy, Security and Legislation Branch which has concluded a Privacy Impact Assessment (PIA), signed off by the Office of the Information and Privacy Commissioner of BC.. A final revision of the privacy statement and supporting policy will be submitted with the PIA to the respective governments and the BC Healthy Living Alliance, in its role to support the Ministry's interests on this project.

SCR is responsible for providing technical support and will soft-launch to test technical issues prior to an announcement. An app demo will be made available to share with the Minister in advance of the announcement. The evaluation framework is being finalized and is led by PHAC and SCR, with the Ministry and the BC Healthy Living Alliance (BCHLA) participating in the process. Dr. Guy Faulkner, who holds a research chair position with UBC in Applied Public Health, will provide an impartial evaluation to the framework. Evaluation of the project includes short, medium and long term measures,

based on behavioural insights theory. SCR will be providing ongoing reporting to the BCHLA and the Ministry of the performance to guide the roll-out of content and demonstrate in-app activity and associated metrics.

Carrot Rewards is the result of a collaborative effort between PHAC, the Ministry (through partnership funding to the BCHLA) and Social Change Rewards along with its national, Non-Government Organizations (NGO) partners (YMCA Canada, Heart & Stroke Foundation and Canadian Diabetes Association). Having the BC Healthy Living Alliance on board complements the national NGO supporters and ensures we are addressing shared priorities toward reducing chronic disease and improved health outcomes.

DISCUSSION:

s.13

OPTIONS:

1. Support a proposed joint event with PHAC, the Ministry, BCHLA, SCR and NGO partners at the end of January 2016, to generate media and engagement opportunities.

s.13

FINANCIAL IMPLICATIONS:

Carrot Rewards is cost-shared by a \$5 million contribution from PHAC to Social Change Rewards and a \$2.5 million contribution by the Ministry, through a partnership with the BC Healthy Living Alliance. The program will reach a potential overall investment of \$12.5 million through in-kind contributions of up to \$5 million by Social Change Rewards. The investment from all parties is over a period of up to five years and is based on a pay-for-performance model.

RECOMMENDATION:

Option 1: Support the launch of Carrot Rewards and consider an opportunity for a joint event in late January 2016.



Approved/Not Approved
Terry Lake
Minister

Jan.11, 2016

Date Signed

Program ADM/Division: Population Health Surveillance and Public Health Planning, PPH

Telephone: 250-952-1467

Program Contact (for content): Regan Hansen, Director Health Engagement Unit

Drafter: Ashley Walden, Senior Manager Health Engagement Unit

Date: updated December 31, 2016

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 6:30 PM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Re: As discussed - Hospice Funding

As far as I know, just made aware -- my impression is this course of action was decided a while back. I placed in the decision folder as we're looking for your direction to proceed with announcement.

If you have concerns, or would like more info, please let me know.

E

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:27 PM
To: Scheffel, Emile HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Re: As discussed - Hospice Funding

This is not presented as a decision note. Am I being asked to approve the proposed designation of funds or just being made aware of it?

Terry Lake DVM
Minister of Health

On Jan 12, 2016, at 11:46 AM, "Scheffel, Emile HLTH:EX" <Emile.Scheffel@gov.bc.ca> wrote:

Minister,

Please see attached BN regarding Centre for Palliative Care. It's on your iPad under Approval > BNs for Decision.

Please let us know if you would like a briefing. Comms advises we could announce in February.

Thanks E

<1042945 - Funding to Support the Commitment to Double Hospice Spaces.docx>

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 6:24 PM
To: Lake, Terry HLTH:EX
Subject: Re: BC Fentanyl Overdose Response and EMA Regulation change

Yeah -- I'll check in with Erika in the morning, sorry about that.

E

Original Message

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:23 PM
To: McCormick, Erika HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Re: BC Fentanyl Overdose Response and EMA Regulation change

I already signed this order. Please confirm.

Terry Lake DVM
Minister of Health

> On Jan 12, 2016, at 4:07 PM, "McCormick, Erika HLTH:EX" <Erika.McCormick@gov.bc.ca> wrote:

>

> Hi Minister,

>

> The attached are on the iPad under:

>

> Approval --> Briefing Notes for Decision --> BC Fentanyl Overdose
> Response and EMA Regulation

>

> Thanks,

>

> Erika McCormick,

> Administrative Assistant to the Honourable Terry Lake Minister of
> Health

> Email: Hlth.minister@gov.bc.ca/ Phone: 2509533547 PO Box 9050 Stn Prov

> Govt Victoria BC V8W 9E2

>

>

> <1044900 IBN - BC Fentanyl Overdose Response.doc>

> <1044900 Appendix B.docx>

> <1046754 EMA Regulation Package Administer Nalaxone.pdf>

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 5:50 PM
To: 'Badger, Derek [JOICA]'
Subject: RE: Janssen (J&J) Letter to Minister Lake

Will do. Given the schedule it may be difficult but will keep you posted.

Thanks Derek.

E

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jni.com>]
Sent: Tuesday, January 12, 2016 4:56 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Let me know if you and Derek (good name) might have a few moments to connect. It would be good to update you both on a few things. I will be at a company meeting up the street. After hours works just as well if you are staying over on the Monday, Tuesday or Wednesday.

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:49 PM
To: Badger, Derek [JOICA]
Subject: RE: Janssen (J&J) Letter to Minister Lake

Derek Robertson (EA) and I will both be there.

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jni.com>]
Sent: Tuesday, January 12, 2016 4:48 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

OK, thanks.

Do you know who from your office will be accompanying the Minister at the FPT meetings next week?

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Badger, Derek [JOICA]
Subject: RE: Janssen (J&J) Letter to Minister Lake

I would love to know! No intel just yet.

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jni.com>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks Emile, that would be great if you could connect me with the new CoS and MA when they are in place.

Do you know when they might be in place? Anyone I might already know from another Minister's office?

To: Badger, Derek [JOICA]; Merrifield, Katy PREM:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks for this, Derek. Happy new year to you, too.

s.22

If I may, I will connect you with the new chief of staff once they are appointed to continue this conversation.

Best,

E

From: Badger, Derek [JOICA] [<mailto:dbadger@its.inj.com>]
Sent: Tuesday, January 12, 2016 4:09 PM
To: Merrifield, Katy PREM:EX; Scheffel, Emile HLTH:EX
Subject: Janssen (J&J) Letter to Minister Lake

Hi Katy and Emile,

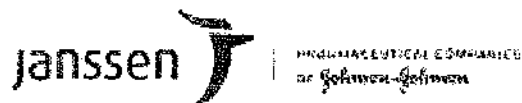
Happy New Year – I hope you are both doing well.

As an FYI, I just wanted to share a letter that has been sent from my President to Minister Lake, sharing our position on National Pharmacare in advance of next week's Health FPT meetings in Vancouver. Let me know if you have any questions or concerns – happy to discuss at your convenience.

Will either of you be attending the Health FPT meetings next week? I will be in Vancouver and would love the opportunity to briefly bring you up-to-speed on the status of our 'Biologics Portfolio Proposal' that we discussed back in October. Let me know if that might work – if not, perhaps we can find a few minutes over the phone sometime soon.

Thanks so much,

Derek Badger
Manager, Government Affairs and Policy
Office: 250.770.1600
Mobile: 250.486.0194



Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 5:07 PM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: Updated: Health Ministers' Meeting Materials
Attachments: DRAFT At A Glance Agenda - Jan 12.pdf; Conference Information e-Binder_Draft Jan 12.pdf

Minister,

The following are now on your iPad for Thursday's briefing.

- At a Glance Agenda (attached)
- Conference Information e-binder (attached – this includes the itinerary)
- Jan 20 – PT HMM e-binder (Not attached – 270 pages)

Health Canada has just sent out the full package of briefing documents, so we will get a binder for the FPT day early tomorrow.

IGR have requested materials on the separate meetings (CFNU, CMA, e-cigarettes) and will add those to the e-binders as soon as they are received.

Thanks E

Page 0024 to/à Page 0047

Withheld pursuant to/removed as

s.16

Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Wednesday, January 13, 2016 1:50 PM
To: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: Fw: Story Board reception in the Legislature for Spring Session

Sent to me by Melissa Nowakowski.

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

From: Nowakowski, Melissa <Melissa.Nowakowski@leg.bc.ca>
Sent: Wednesday, January 13, 2016 1:33 PM
To: Robertson, Derek HLTH:EX
Subject: FW: Story Board reception in the Legislature for Spring Session

Just FYI

From: Hosseinzadeh, Nick
Sent: Wednesday, January 13, 2016 12:49 PM
To: Nowakowski, Melissa <Melissa.Nowakowski@leg.bc.ca>
Subject: RE: Story Board reception in the Legislature for Spring Session

Hey Melissa!

Happy New Year! I just wanted to close the loop on this and was wondering if you had a chance to speak to Val yet?

Thanks so much!

Nick

From: vtregillus@doctorsofbc.ca [<mailto:vtregillus@doctorsofbc.ca>]
Sent: December 14, 2015 1:17 PM
To: Hosseinzadeh, Nick <Nick.Hosseinzadeh@leg.bc.ca>
Cc: Thornthwaite.MLA, Jane <Jane.Thornthwaite.MLA@leg.bc.ca>
Subject: Story Board reception in the Legislature for Spring Session

Hi Nick.....several weeks ago, Jane kindly indicated that she thought it would be a good idea to have the Collaborative's story boards in the Legislature during the Spring Session. The story boards represent the work of both the Local Action Teams and system working groups. We understand there is a cost to the reception and we have alerted Shared Care Committee. Jane indicated there would be someone in the Legislature that we could work with to plan the story board reception. Would you be so kind as to connect me with that person. Thanks so much Nick.

On another note, we have been working closely with the Ministries to look at the last year of the Collaborative 2016/17 – map all the initiatives/policy directions occurring for CYMHSU – and given current state, create the direction for 16/17 through a collaborative process with all of the partners. The wording will be drafted as an additional section to the



OFFICE CLOSURE ALERT: Please note that Doctors of BC will be CLOSED from December 24 2015 – January 4 2016.

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Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Wednesday, January 13, 2016 1:38 PM
To: Scheffel, Emile HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: McCormick, Erika HLTH:EX; Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Stearn, Anne HLTH:EX; Lowe, Tracey HLTH:EX
Subject: Re: Hlth Cabinet Items

MTL has signed off.

Please advise next steps.

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

From: Scheffel, Emile HLTH:EX
Sent: Wednesday, January 13, 2016 11:53 AM
To: Robertson, Derek HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: McCormick, Erika HLTH:EX; Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Stearn, Anne HLTH:EX; Lowe, Tracey HLTH:EX
Subject: Re: Hlth Cabinet Items

Thanks Derek

From: Robertson, Derek HLTH:EX
Sent: Wednesday, January 13, 2016 11:52 AM
To: Andrachuk, Andrea HLTH:EX; Scheffel, Emile HLTH:EX
Cc: McCormick, Erika HLTH:EX; Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Stearn, Anne HLTH:EX; Lowe, Tracey HLTH:EX
Subject: RE: Hlth Cabinet Items

Hey Andrea,

It was sent over with me to Vancouver and I will put it before him after early this afternoon.

Derek

From: Andrachuk, Andrea HLTH:EX
Sent: Wednesday, January 13, 2016 11:43 AM
To: Scheffel, Emile HLTH:EX
Cc: McCormick, Erika HLTH:EX; Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Stearn, Anne HLTH:EX; Lowe, Tracey HLTH:EX; Robertson, Derek HLTH:EX
Subject: Hlth Cabinet Items

Hi Emile,

Please find attached an updated table of the Health items going to Cabinet in the next month.

Andrea Andrachuk | Manager Executive Operations | Office of the Deputy Minister | Ministry of Health | P: 250.952.1908 |
C: 250.217.3655 | F: 250.952.1909 | andrea.andrachuk@gov.bc.ca

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ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE Ministry: Health Date: January 13, 2016 Minister Responsible: Terry Lake	Patient on patient violence in residential care/provincial approach to dementia care

BACKGROUND REGARDING THE ISSUE:

- The ministry and health authorities take the safety and well-being of people living in residential care very seriously.
- Residential care facilities work to provide a home-like environment that strives to balance the need to keep residents safe with the human need for social interaction, freedom of movement and the routine of everyday life, including recreational opportunity and shared meals.
- These facilities also manage the challenge of residents with cognitive impairment (such as dementia) who at times exhibit verbal and physical aggression.
- Staff are trained in intervention and distraction techniques that aim to de-escalate these situations, while at the same time preserving the dignity of people in care.
- Health authorities are increasing awareness and training for staff to better care for clients with complex physical and cognitive/mental health needs and behaviour changes through education programs for residential care staff, such as P.I.E.C.E.S.; and working with the BC Patient Safety and Quality Council (BCPSQC) on CLeAR – a Call for Less Antipsychotics in Residential Care – with a goal to reduce inappropriate use of antipsychotics in residential care homes.

Provincial dementia plan:

- In terms of dementia statistics, there are up to 60,000 British Columbians currently living with Alzheimer's or a related dementia.
- This is not unique to British Columbia, Canada or the world. The ministry, health authorities and front line staff have taken important steps forward to improve the care of people with Alzheimer's and dementia and their caregivers.
- We know that people with dementia can sometimes be unpredictable in their behaviour and it may not be possible to reduce every instance of aggression or violence.
- With this in mind, the Province is in the process of finalizing a provincial approach to dementia care.
- The new plan builds on the 2012 Provincial Dementia Action Plan – which outlines province-wide priorities for improved dementia care.
- Priorities identified in the new approach:
 - Increase public awareness and early recognition of cognitive changes;
 - Support people with dementia to live safely at home for as long as possible and support caregivers;
 - Improve quality of dementia care in residential care including palliative and end-

of-life care; and,

- Increase system supports and adoption of best practices in dementia care.
- In alignment with the ministry's priority to better meet the needs of older adults, this approach will include standards of care that will guide the transition to residential care should it be needed.
- The approach includes steps to enhance dementia-specific quality standards of care in residential care, and increasing and sustaining consistent dementia care training for health care professionals and care givers – including cultural competency training – in all care settings.

For example:

- Launching a public awareness plan to increase understanding of dementia and continue to expand community information and support programs (e.g., Dementia-Friendly Communities) for people with dementia and their caregivers.
- Increase awareness of healthy behaviours associated with risk reduction for certain types of dementia and promote brain health for all ages while targeting midlife individuals.
- Enhance the ability of health care professionals to detect and diagnose cognitive changes, provide appropriate and culturally sensitive treatment and link people with dementia and their families to information and community supports such as First Link.
- Review, modify and/or expand home care services including flexible respite programs and supports for people with dementia and their caregivers.
- Review and enhance workplace policies for people with dementia and caregivers.
- Develop a care pathway for the identification, management and care of people with dementia starting with diagnosis and including transitions in care.
- While some of the plans will be led by the ministry (for example, public awareness strategies) others require implementation by health authorities.
- Two key priority actions underway are the provincial strategy to address wandering; and the renewal of the license with P.I.E.C.E.S. Canada for extended dementia care training.
- The provincial strategy to address wandering has been developed in partnership with representatives from the Alzheimer's Society of B.C., the Ministry of Public Safety and Solicitor General (PSSG), health care providers, family caregivers, local government and police.
- It includes new resources for people with dementia and their families to prevent wandering from occurring; a best-practice toolkit to prevent wandering within, and from, residential care settings; resources to help community members identify a person who has wandered, including resources to assist in their safe return; and working with PSSG to provide police with resource information about dementia and common wandering behavior to assist in the location and safe return of someone who has wandered.
- Renewal of the license for dementia care training with P.I.E.C.E.S. Canada will support health authorities who are working to sustain and grow a critical mass of providers trained in P.I.E.C.E.S. and to achieve a consistent language and care approach for

ADVICE TO MINISTER

people with challenging behaviors associated with dementia.

- As of November 2015 over 1500 health care providers have received 3-day training sessions in P.I.E.C.E.S. across 226 facilities, and approximately 35 facilitators are trained to lead these sessions.
- Over the next coming months the ministry will be working with health authorities to plan for the integration of dementia care identified in the strategy.

DISCUSSION/ADVICE:

s.13

ADVICE AND RECOMMENDED RESPONSE:

- We know that some people with dementia can be unpredictable in their behaviour and it may not be possible to reduce every instance of aggression or violence. However, there is absolutely more we can do.
- That is why we are in the process of finalizing a provincial approach to dementia care.
- The new strategy builds on the 2012 plan, and places dementia patients, their families and caregivers at the centre.
- In alignment with the ministry's priority to better meet the needs of older adults, this approach will include standards of care that will guide the transition to residential care should it be needed.
- The approach includes actions to enhance dementia specific quality standards in residential care, and increasing and sustaining consistent dementia care training for health care professionals and care givers – including cultural competency training – in all care settings. For example:
 - Launching a public awareness plan to increase understanding of dementia and continue to expand community information and support programs for people with dementia and their caregivers.
 - Helping health care professionals detect and diagnose cognitive changes, provide appropriate and culturally sensitive treatment and link people with

dementia and their families to information and community supports such as First Link.

- Reviewing and enhancing home care services, including flexible respite programs and supports for people with dementia and their caregivers.
- Reviewing and enhancing workplace policies for people with dementia and caregivers.
- Developing a stronger care pathway for the identification, management and care of people with dementia, starting with diagnosis and including transitions in care.
- Two key priorities underway are the provincial strategy to address wandering, and the renewal of the license with P.I.E.C.E.S. Canada for extended dementia care training.
 - The provincial strategy to address wandering has been developed in partnership with representatives from the Alzheimer's Society of B.C., the Ministry of Public Safety and Solicitor General, health care providers, family caregivers, local government and police, and will include:
 - New resources for people with dementia and their families to prevent wandering from occurring.
 - A best-practice toolkit to prevent wandering within, and from, residential care settings.
 - Resources to help community members identify a person who has wandered, including resources to assist in their safe return; and
 - Working to provide police with resource information about dementia and common wandering behavior to assist in the location and safe return of someone who has wandered.
 - Renewal of the license for dementia care training with P.I.E.C.E.S. Canada will support health authorities who are working to sustain and grow the number of providers trained in P.I.E.C.E.S. and to achieve a consistent language and care approach for people with challenging behaviors associated with dementia.
 - As of November 2015 over 1,500 health care providers have received three-day training sessions in P.I.E.C.E.S. across 226 facilities, and approximately 35 facilitators are trained to lead these sessions.
- Over the coming months the ministry will be working with health authorities to finalize this plan.

Communications Contact:

Brent Shepherd

Reviewer:

Laura Heinze

Program Area Contact:

File Created:

Jan. 11, 2016

File Updated:

Minister's Office	Program Area	Deputy	HLTH Communications

Scheffel, Emile HLTH:EX

From: Jukes, Shaina HLTH:EX
Sent: Wednesday, January 13, 2016 1:23 PM
To: Dhanowa, Damon HLTH:EX; Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: FW: Representative For Children and Youth Report
Attachments: RCY_PlacementinHotels-Jan2016FINAL.PDF

FYI

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: The Speaker [<mailto:Speaker@leg.bc.ca>]
Sent: Wednesday, January 13, 2016 1:23 PM
To: Barnettson, Luella MNGD:EX; Blakesley, Nicki TRAN:EX; Blonde, Sarah MTIC:EX; Borschneck, Lindsay TRAN:EX; Costa, Sarina MEM:EX; Davidson, Tamara PREM:EX; Flesh, Cindy AVED:EX; Johnson, Lisa E AGRI:EX; Jones, Angela MIT:EX; Jukes, Shaina HLTH:EX; Kennard, Kimberley PSSG:EX; King, Wendy L MCF:EX; La Forge, Jessica JTST:EX; Leamy, Michelle T PREM:EX; Marquis, Yvette FIN:EX; McKnight, Valerie SDSI:EX; O'Connor-Dixon, Lara EDUC:EX; Robbins, Lia CSCD:EX; Roberts, Connie A ABR:EX; Scott, Heidi ENV:EX; Silverio, Lisa FLNR:EX; Walker, Nikki JAG:EX
Subject: Representative For Children and Youth Report

Attached you will find the Representative For Children and Youth report, The Placement of Children and Youth in Care in Hotels in British Columbia.
The report can also be found on the Representative's web site.

<https://www.rcybc.ca/reports-and-publications/reports/cid-reviews-and-investigations/hotels>

The Placement of Children and Youth in Care in Hotels in British Columbia

A Joint Special Report

January 2016



REPRESENTATIVE FOR
CHILDREN AND YOUTH



Ministry of
Children and Family
Development

Jan. 13, 2016

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

We have the honour of submitting to the Legislative Assembly of British Columbia this joint special report *The Placement of Children and Youth in Care in Hotels in British Columbia*. This report is prepared in accordance with Section 20 of the *Representative for Children and Youth Act* and s. 93(2) of the *Child, Family and Community Service Act (CFCS Act)*.

Sincerely,



Stephanie Cadieux
Minister of Children
and Family Development



Mary Ellen Turpel-Lafond
Representative for
Children and Youth

pc: Mr. Craig James, QC
Clerk of the Legislative Assembly

Ms. Jane Thornthwaite, MLA
Chair, Select Standing Committee on Children and Youth

Acknowledgements

This report is a recognition of the needs of all children and youth to be raised in a family setting. The Minister and Representative would like to thank the many staff members in both organizations who worked diligently in a spirit of collaboration to complete this joint report within a challenging time frame. Thanks are also extended to the Ministry and Delegated Aboriginal Agency staff interviewed for the report. We believe the results will help inform an improved child protection system in British Columbia moving forward.

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Introduction

This Joint Special Report is a collaborative initiative undertaken by the Ministry of Children and Family Development (MCFD) and the Representative for Children and Youth (RCY). In September 2015, a British Columbia youth in care died while he was placed in a hotel. This special report was initiated after that tragedy in order to examine the practice of placing children and youth in care in hotels, with the common goal of improving child welfare practice across the province. This report is not child- or incident-specific; rather, it is an examination of the circumstances that may result in children and youth being placed in hotel settings. This report is being prepared in accordance with s. 20 of the *Representative for Children and Youth Act (RCY Act)* and s. 93(2) of the *Child, Family and Community Service Act (CFCS Act)*.

This report is consistent with the approach suggested in the 2006 Hughes Review of B.C.'s child welfare system, when former justice Ted Hughes recommended "*the representative take part in the development of policies or practices that reflect a deeper understanding of the needs and interests of children, youth and their families.*"¹

Methodology

This report has been informed by a review of relevant literature and comparative information drawn from: Directors of Child Welfare; child and youth advocates across Canada; consultation with subject matter experts; and joint interviews conducted with MCFD and Delegated Aboriginal Agency (DAA) staff, supervisors and contracted service providers. A total of 17 interviews were completed with eight MCFD staff, seven DAA staff and two child care workers who are employed by a contracted agency. Also incorporated in the report is recent data on current rates of hotel usage, along with a snapshot of the characteristics of the children and youth in care who are being placed there.

¹ Honourable Ted Hughes OC, QC, LL.D. (2006). BC Children and Youth Review: An Independent Review of BC's Child Protection System.

Terms of Reference

This report aims to address the following questions relating to the practice of placing children and youth in care in hotels in B.C.

- What is the historical and current usage of hotels and what are the characteristics of the children and youth being placed in them?
- Why are hotels being used as placements?
- Who is being tasked with caring for children and youth during their hotel stays and what training and qualifications do they possess?
- What are the potential risks associated with these placements?
- What policy and practice guidelines would be appropriate to minimize the use of hotels as placements, ensure accountability and accurate reporting, and provide for appropriate levels of external oversight?
- What recommendations can be made to ensure that the use of hotels for children and youth in care is reduced or eliminated and what tracking, reporting, and accountability measures can be used to support this?

The Historic Context

Neither provincial legislation nor MCFD's own internal residential care standards and policies have ever specifically addressed the practice of placing children and youth in care in hotels or other temporary lodgings in B.C. Section 71 of the *CFCS Act* provides that social workers are required to consider the child or youth's best interests in deciding on where they should be placed.

"The practice has always been that it is the absolute last resort when we have absolutely nothing else to offer."

– Community services manager,
regarding hotel placement

Ministry policy covering the placement of children and youth in care before 2012 was contained in the *Child in Care Standards* (Standard 12) and *Child and Family Service Standards* (Standard 20). After 2012, the *Child Protection Response Policies* (3.5(8)) replaced the *Child and Family Service Standards*. For DAAs, these policies were contained in *Aboriginal Operational and Practice Standards and Indicators* (AOPSI). All these policies require that social workers place children and youth, when possible, with or near relatives and friends, with their sibling group, in a location that allows the child or youth to continue in the same school and, in the case of Aboriginal children, with extended family or within their Aboriginal community.

None of these ministry policies contain any reference to placing children or youth in hotels, nor do they contain any specific prohibition of this practice. Despite this lack of policy to support hotel placements, the ministry and DAAs have, going back to at least the 1990s, placed children and youth in care in hotels.

In November 2014, MCFD directed social workers to obtain the approval of senior ministry officials before placing a child or youth in a hotel and began tracking the practice. This followed public attention on the issue of hotel placements in Manitoba, where the government has been under scrutiny for many years over its regular housing of children and youth in hotels and motels. That province has since issued an official directive forbidding the use of hotels as placement locations, even on a temporary or emergency basis, and created a Hotel Reduction Team to oversee this directive.²

On Nov. 30, 2015, Manitoba's Minister of Family Services announced that the province had ended the use of hotels as emergency placements for children and youth with the addition of 55 emergency shelter beds and 114 emergency foster beds.³

Statistics on MCFD Children and Youth in Care Placed in Hotels

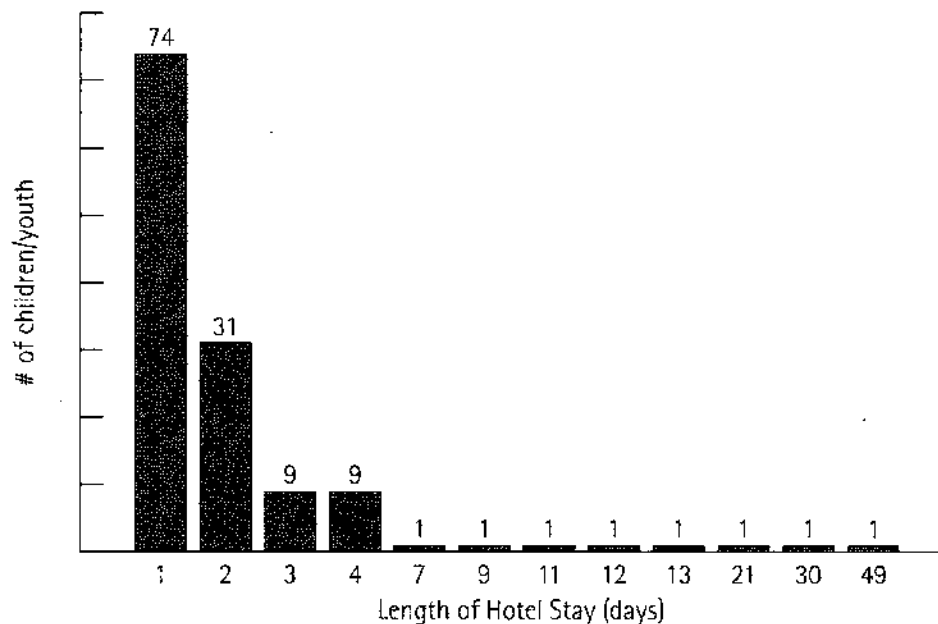
MCFD has had the ability to track hotel stays on its electronic databases since 1996. However, in the absence of any policy or procedures on the recording of such stays, data gathered prior to November 2014 is unreliable. With the introduction of the Integrated Case Management (ICM) system in 2012, it was possible for social workers to indicate a hotel placement was being used, but many were unaware of this. While the data indicates that the practice of using hotels is longstanding, there is no way to accurately assess the frequency with which it has occurred.

In September 2014, the B.C. Provincial Director of Child Welfare (PDCW) surveyed Executive Directors of Service and Executive Directors of DAAs in an effort to quantify the number of children and youth being placed in hotels. This survey and a search of MCFD's internal data suggested that fewer than 20 children and youth were being placed in hotels per year. In November 2014, based on concerns about the impact of this practice, the PDCW issued a directive to all Executive Directors of Service and DAAs requiring that any further hotel placements occur only with the explicit approval of a designated Director. This directive also included mandatory reporting of the occurrence and duration of the hotel stay to the PDCW. Although it is impossible to verify complete compliance with this directive, it does provide the most accurate information currently available. The manual tracking by the PDCW of each placement from November 2014 to October 2015 recorded the placement of a total of 117 children and youth in care in hotels (Fig. 1).

² Manitoba Family Services. *Child and Family Services Standards Manual 1.4.3. Use of Hotels*. (2015). Retrieved from <http://www.gov.mb.ca/fs/cfsmanual/1.4.3.html>

³ Government of Manitoba. (2015) Manitoba government meets timeline to end use of hotels for youth in care. [News release]. Retrieved from <http://news.gov.mb.ca/news/index.html?item=36910>

Figure 1: Number of Children and Youth in Care (CYIC) by Duration of Hotel Stay (days) Over 12 Months (November 1, 2014 to October 31, 2015)



Note:

1. A child may be counted more than once.

2. A child may have more than one episode in a hotel placement.

In September 2015, following the death of a youth in care in a hotel in the Lower Mainland, the PDCW sent further direction to ministry and DAA staff, reinforcing the importance of seeking approval for any hotel placement. Since then, the majority of placements have been approved by the Deputy Director of Child Welfare, with the remainder being approved by other designated directors in the regions. To date, every request made by a social worker for a hotel placement has been approved. The PDCW continues to manually track each placement until such time as clear policies and procedures can be implemented to allow this to be done electronically.

Between November 2014 and October 2015, 117 children and youth were placed in hotels. Some were placed in hotels more than once during this time period, resulting in a total of 131 hotel placements. Nine children and youth stayed in a hotel twice, one was placed in a hotel three times and one was placed four times. Among the 131 placements, the average stay was 2.7 days, although about half (55 per cent) only lasted a single night.

"Our goal is always to get them out of a hotel as quickly as possible. I think our goal is always to get them in a family care home..."

– Contract manager with MCFD

"Currently in Surrey – and Surrey is a good indicator for Langley, Delta and Surrey – [foster homes] are running at 103 per cent occupancy, meaning that we have more children in those homes than we have available beds, technically."

– Resource Team Leader in the Lower Mainland

Hotel Stays by Service Delivery Area/Delegated Aboriginal Agency

The use of hotels has varied widely across the province. Two Service Delivery Areas (SDAs) and 14 DAAs (with guardianship responsibility) placed no children in hotels during the 12-month period. Four SDAs and two DAAs used a hotel placement for only one child in care during that time. Two SDAs – North and South Fraser – placed children and youth in care in a hotel 27 and 32 times, respectively, in the same period. Fraser Valley Aboriginal Child and Family Services Society and Vancouver Aboriginal Child and Family Services Society have placed children and youth in hotels 12 and nine times, respectively. The frequency with which hotels are used is linked to the availability of more conventional placements such as foster homes and group homes.

Table 1: Hotel Placements by SDA/DAA

Service Delivery Area/Delegated Aboriginal Agency	Average # of CYIC*	# of hotel placements
Province**	5,738	131
SDA Kootenays	170	1
SDA East Fraser	410	8
SDA North Fraser	421	27
SDA South Fraser	773	32
SDA Vancouver/Richmond	338	14
SDA Coast/North Shore	211	1
SDA South Vancouver Island	675	1
SDA North Vancouver Island	719	6
SDA Northwest	207	9
SDA North Central	390	2
SDA Northeast	103	1
Fraser Valley Aboriginal Children and Family Services Society	453	12
Vancouver Aboriginal Child and Family Services Society	403	9
Secwepemc Child & Family Services	188	2
Métis Family Services	120	2
Northwest Inter-nation Family Services Society	30	2
Ktunaxa-Kinbasket Family & Child Services	59	1
Ayas Men Men Child & Family Services	69	1

Note:

1. Figures only include a SDA or DAA who placed a child/youth in a hotel between Nov. 1, 2014 to October 2015.

2. Figures include children/youth who have been placed more than once.

* Average number of CYIC between November 2014 to October 2015 (12 month average).

** 5,738 is the average monthly caseload for SDA or DAA that had a hotel placement. The total provincial average monthly caseload was 7,542.

Some of the MCFD staff interviewed stated that they had never used hotels for placements, in some cases because they had no access to hotels or no child care workers to staff them, or because there was no tradition of using hotels in the SDA and so they simply never considered it an option.

Demographics of Children and Youth in Care Placed in Hotels

Of the children and youth in care placed in hotels, 52 per cent were Aboriginal and 48 per cent were non-Aboriginal. Currently, Aboriginal children and youth make up approximately 60 per cent of the total number of children in care in B.C. Sixty-one per cent of those placed in hotels were female. Just over half (54 per cent) of the children and youth were teenagers (13 to 18 years). Only 15 per cent were under the age of five years at the time they were placed in a hotel.

Figure 2: Aboriginal/non-Aboriginal Children in Care Placed in Hotels

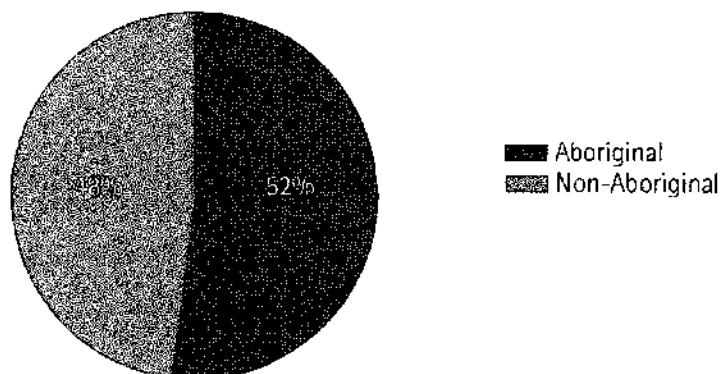
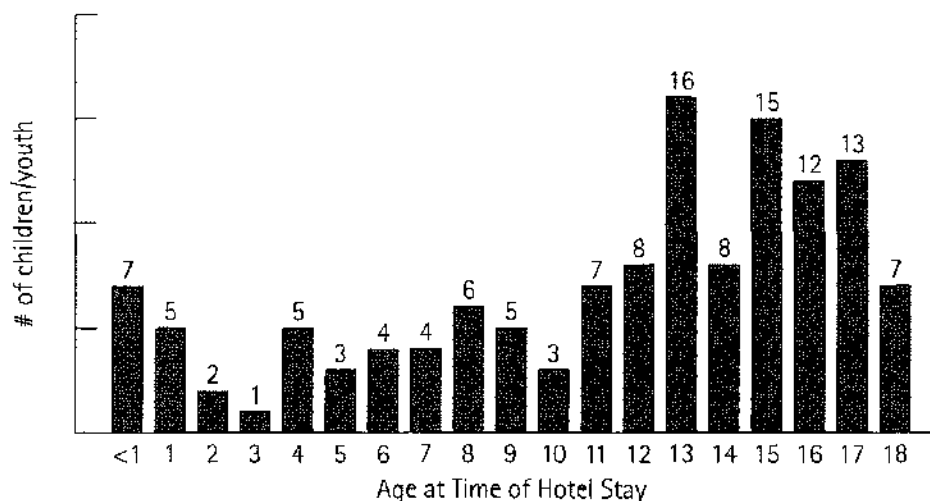


Figure 3: Number of Hotel Stays of Children and Youth in Care by Age at Time of Placement



Note:

1. A child may be counted more than once.
2. A child may have more than one episode in a hotel placement.

MCFD and DAA staff interviewed described the children they were placing in hotels as predominantly being between 10 and 15 years of age, with some instances of infants and youth on the verge of “aging out” of care. They emphasized that these children tended to present with significant special needs and unique circumstances. One interviewee also felt there were particular challenges for 10 to 13 year olds who were too young for group home placement and whose need for a more familial setting meant placement in a hotel until a foster home could be located.

Reasons for Hotel Placements

The vast majority of children and youth being placed in hotels fall into two distinct categories:

- Those who are being taken into care unexpectedly, often outside regular business hours. These are typically young children who are removed because they are in immediate danger or older children or youth being taken into care by agreement with their parents because they can no longer live at home; and
- Those children and youth already in care whose existing placement has broken down.

In both these categories, most of the hotel placements resulting from placement breakdowns occur during the evenings or weekends. Most SDAs and DAAs contract for emergency foster homes or beds within existing resources that are dedicated to urgent and unexpected short-term placements. Many of those interviewed reported that these emergency beds are often already full because of lack of capacity elsewhere in the system.

"The profile of the child is less indicative than the capacity of the network to place the child."

– Resource team leader
in Lower Mainland

MCFD and DAA staff interviewed for this report provided a variety of reasons why hotel placements are utilized, including:

- no available beds in foster homes or residential service providers in the area or any of the surrounding areas
- the child or youth could not be appropriately placed with other children or youth in a foster setting because of age and gender differences
- the child or youth could not be placed with other children or youth because of behaviours that would put them at risk of harm
- the child or youth's mental health or special needs made it impossible to locate an existing caregiver with appropriately matched skills and capacity, and time was required to create a new specialized resource
- one interviewee working in the North attributed the lack of mental health beds in hospitals for youth in crisis as another reason for a hotel placement.

One MCFD staff member and one DAA staff member interviewed attributed the increase in hotel usage they had observed over the previous two to three years to the increasing complexity of the children and youth coming into care and the inability to locate a suitable placement for them.

One example of this was a 14-year-old boy who came into care due to his parent being unable to manage his behaviours. The boy's behaviours were also beyond the capacity of his foster parents to manage. A search for an alternative home revealed that other available foster homes in the area also lacked the specialized skills this boy required. With no immediately available alternatives, he was placed in a hotel while a specialized resource was developed for him.

With the increased attention provided by the PDCW since September 2015, the data suggest that the majority of hotel placements since then have been made by provincial After Hours staff during the weekend and late night hours. The primary reasons provided to the PDCW by ministry and DAA staff are:

- a shortage of emergency beds
- After Hours does not always have access to up-to-date list of available foster homes
- After Hours workers cannot reach a resource social worker to ascertain availability of beds because they have no contact information or the resource social worker does not respond to calls made outside regular business hours
- After Hours can't reach a potential foster home placement because the contract with the foster parent does not require 24-hour availability
- reduced capacity during times when After Hours workers are required to transport children or youth to foster homes, leaving them unavailable to respond to urgent child protection matters
- SDAs and DAAs don't necessarily coordinate or share foster home resources
- insufficient number of "safe baby"-trained foster parents.

After Hours Service –

Operates the toll-free Provincial Helpline for Children (310-1234), a 24-hour emergency service for all MCFD program areas. In addition, the After Hours program provides call-out social workers for emergencies throughout the province and support for social workers in remote locations.

Safe Baby Training – The Safe Babies Program was developed in 1998 and was intended to respond to the need for highly skilled caregivers who could take care of substance-exposed infants. The SB training program consists of four intensive modules addressing topics such as acute withdrawal in the newborn, the effects of substances on the body, understanding the impact of using substances during pregnancy, and health issues that may be relevant to substance-exposed infants.

Supervision for Children and Youth in Care in Hotels

Ministry policies on placement of children and youth in care require that individuals caring for them be ministry-approved “caregivers.” This includes residential resources developed for special purposes such as foster homes used for emergency, short-term placements.

Social workers, particularly in the Lower Mainland, often use child care workers from a contracted agency to supervise and care for a child or youth during a hotel stay when an approved caregiver is not available. If a child care worker is not available, family support workers or social workers may be used to provide supervision.

Child care workers are subject to a criminal record check but are not subject to the same criteria for approval as caregivers. Child care workers typically possess a one-year human services certificate and basic first aid training. They may have further training in subjects such as non-violent crisis intervention or working with special needs populations, but do not receive the training that is mandatory for foster parents. Although specific training in Aboriginal cultural competency and working with children with significant histories of trauma would be an asset, this is not currently a requirement of employment. Finally, child care workers do not necessarily receive the same level of oversight, supervision and support that caregivers do.

MCFD and DAAs in the Lower Mainland are reliant on one contracted agency to provide child care workers. After Hours workers are the primary users of this service.

Agency staff reported that when they are contacted to assist with supporting a child or youth in a hotel placement, they are provided with a referral document that includes information about the child’s medications, routines, and contact information for the responsible social worker and After Hours in case of an emergency. Child care workers can work long shifts of 12 to 20 hours, in part because these longer hours provide more continuity for the child or youth in their placement.

The expectation is that the child care workers will provide constant supervision to the child or youth as well as providing opportunities for them to participate in recreational activities. If a child is attending school or day programming, the expectation is that the child care worker will support that by ensuring attendance.

Once the child care worker and the child or youth have arrived at a hotel, the focus for the worker is on engaging the child or youth in an activity until they are asleep. Staffing in these situations is normally one worker, although this may increase if there are particular concerns about high-risk behaviour or if more than one child or youth is being cared for.

“The whole purpose is to make sure that the client is safe and cared for for a short period of time until another plan can be put together.”

– Executive Director of agency providing child care workers

“So, a typical shift looks like we will pick up the kids from the district office, After Hours, cells, the police station. Sometimes we pick them up in youth psych at Children’s Hospital – all different types of places where they’d be coming from.”

– Child care worker

Impacts on Children and Youth in Care Placed in Hotels

Research on the impact of hotel placements on children and youth in care is sparse, likely because child welfare organizations do not consider hotels to be appropriate placements for the children and youth for whom they serve as guardians. However, hotels are often used as a result of a placement breakdown, represent a move for the child or youth along with a change in caregiver, and are inherently temporary. The literature on the negative effects of placement breakdowns and frequent placement moves on children and youth in care is quite rich.^{4, 5}

Placement instability, sometimes referred to as “foster care drift,” may be more likely among children and youth who are placed in hotels because of a breakdown in a regular resource.⁶ Children and youth for whom it is more challenging to find regular resources will encounter more frequent placement breakdowns and placements of shorter duration than others due to their complex needs. Aboriginal children and youth also experience more placement instability. A 2012 U.S. study concluded that children with three or more placement changes were significantly more likely to suffer recurrent crises than those with stable placements.⁷ The same study also found placement instability was linked to mental health problems and a need for emergency mental health services.

Interviews with MCFD and DAA staff revealed a range of opinions on the impact of hotel stays on children and youth. Most staff cited the immediate safety benefits provided by placing the child in a controlled setting with close supervision. One manager with a contractor providing child care workers to MCFD felt strongly that children and youth benefited from having the one-on-one attention that could be provided in this setting, particularly when it came in the aftermath of a traumatic event.

But most interviewees also recognized there are significant negative impacts, many related to the short-term and stop-gap nature of the placement. Children and youth placed in hotels because of placement breakdown are more vulnerable and often feel rejected, stressed and depressed – emotions that may be reinforced by placing them in an inherently transient environment with an adult whose relationship with the child or youth is also likely to be brief.

“All I can think in their little heads is they’re thinking: ‘they can’t find one person who wants me?’”

– DAA team leader

Children and youth may be stressed by the uncertainty of where they will be placed permanently, including the possibility that they could be placed outside their home community.

⁴ General Child and Family Services Authority. (2009). *Shelrer analysis: April 1, 2008 – March 31, 2009*. [Unpublished report].

⁵ Burnside, L. Office of the Children's Advocate, Manitoba. (2012). *Youth in Care with Complex Needs*. Retrieved from <http://www.childrensadvocate.mb.ca/wp-content/uploads/Youth-with-Complex-Needs-Report-final.pdf>

⁶ Andersen, S. H. (2014). Complex Patterns: On the Characteristics of Children Who Experience High and Low Degrees of Foster-Care Drift. *British Journal of Social Work*, 44, 1545-1562.

⁷ Fawley-King, K. (2012). Relationship between Placement Change during Foster Care and Utilization of Emergency Mental Health Services. *Children and Youth Services Review*, 34, 348-353.

Child care workers also expressed concern that a lack of planning may exacerbate a child's feelings of uncertainty. For example, a child who has been placed in a hotel on a weekend may feel stressed by the uncertainty of being taken to visit his or her social worker on Monday morning only to find that the worker is not present or that no planning had taken place prior to their arrival at the office.

"...I can't really soothe the child in telling them what's coming next."

– Child care worker

Other risks identified included the potential jeopardy to child care workers who may have insufficient information about the behaviours of a youth or who are unable to form a relationship quickly enough to prevent a child from running away from the hotel. Interviewees described circumstances of children and youth leaving their hotel placement, "going AWOL," and requiring police assistance to locate and return them.

DAA Experiences

Interviews with staff from DAAs were similar to their MCFD counterparts with respect to their reluctance to place children or youth in hotel settings and their perception that the children and youth had more complex needs. They said that hospitals were reluctant to hold children or youth with mental health needs overnight and that premature discharge of those children and youth placed an additional burden on the agency to find a placement. Efforts to reduce the number of youth being held in custody prior to trial also increased pressure on existing residential resources.

DAA staff were clear, however, in their assertion that MCFD and After Hours had access to more resources, including beds assigned to Youth Probation and group home spaces. The inability to support and maintain resources within their own agency meant that they were forced into using hotels as a last ditch measure.

"We don't have the funding parameters to just have empty beds. We try not to use hotels, but until that changes I don't really know what we can do."

– DAA team leader

DAAs' inability to directly contract with child care worker agencies was also cited as a hindrance.

The DAAs also had concerns that their foster parents were aging and that younger parents who would have the ability and willingness to engage with more challenging adolescents were not being recruited.

Reducing Reliance on Hotel Stays

Virtually every interviewee who was asked about the best strategies for reducing reliance on hotel stays related the issue to the shortage or absence of alternative placements during emergency situations, whether in foster homes, group homes or some other resource. There is a clear perception that existing resources are either full or even over-capacity and that there is no residual capacity to cope with emergency placements.

One worker suggested there was a need to recruit foster homes that would be willing and have the ability to provide care, even to youth with complex behaviours, outside normal business hours.

Aligned with these ideas was support for the idea of targeted foster parent recruitment. This would involve recruiting those who have specific cultural competencies, skills in caring for children with special needs and particularly adolescents with high-risk behaviours. Other suggested solutions focused on the creation of additional beds within existing resources, although some expressed concern about the risk of these being quickly filled, once again leaving no capacity to accommodate urgent needs.

Still other suggestions centred on the importance of supporting existing placements so that they would be less likely to break down and force social workers to scramble to find alternatives. For children with complex behaviours, suggestions included providing foster families with robust support from complex care coaches, access to relief caregivers to relieve some of the pressures on the primary family, and the use of a “wraparound” model to ensure families are appropriately supported.

Wraparound – Wraparound is a method used to build an individualized plan of care through collaboration between children and youth with complex needs, their families and their support networks. Wraparound is different from traditional service delivery in that it focuses on connecting children and youth with the supports they need in order to address specific problems, and if one intervention does not seem to be working, services can be reconfigured to better suit the child or youth’s needs. The intent of wraparound is to try to maintain children or youth who have serious emotional or behavioural problems within their communities.

“The more resources we have, the less likely we are to use hotels. As I said, there likely will always be those one-offs where we might have to go back to a hotel, but at the end of the day the more available resources we have, the less likely we are to utilize hotels.”

– MCFD manager

“I think we should be recruiting for emergency homes for high-risk youth for short-term stays and that it should be funded differently.”

“Instead of a time-out in a hotel, could we take a time-out in their community with a child care worker? Could we be rebuilding some kind of cultural grounding for that young person as we navigate forward?”

“And we don’t seem to have effective resources in place to address these kids while they’re still in a foster home or while their behaviours are still somewhat manageable. I don’t have a solution, clearly, just frustration.”

– DAA resource social workers

For older youth transitioning into independence, a supportive housing model with full-time resident staff to support youth was also recommended.

Analysis

Given the previous absence of any MCFD policy about the use of hotel placements, the ministry has, in consultation with DAAs, developed a practice directive that will provide clear guidance to MCFD and DAA staff in these situations. This directive (Appendix A) includes the identification of those responsible for authorizing such placements, the procedure for ensuring such a placement is correctly recorded on the ministry's ICM system (Appendix B), the necessary qualifications of those tasked with caring for children or youth in these placements and the mandatory ongoing reporting about the status of the child or youth to the PDCW.

To ensure that appropriate external oversight on the use of hotel placements is provided, the directive also includes a mandatory reporting requirement, directing that the PDCW notify the Representative for Children and Youth of any child in a hotel placement of three days duration or longer.

The Minister of Children and Family Development has committed to publicly reporting every six months on the use of hotel placements.

In the longer term, it is clear that the use of hotel placements is an indication of significant shortfalls in other available residential placements, including foster homes, emergency beds, and group homes. Like Manitoba, B.C. must begin an immediate process to close the service gaps and develop a clear plan to address these gaps in a timely fashion, with the ultimate goal of eliminating hotel placements entirely. Key to that will be supporting the necessary resource enhancements and implementing processes for more effective use of existing capacity, particularly after regular business hours.

Action Plan

As a result of this review, MCFD has committed to the following actions:

1. The ministry has released a Practice Directive (Appendix A) to ministry staff and DAAs regarding the use of hotels, the approval process, tracking, monitoring and oversight of hotel stays, supports provided to the child in the hotel, the qualifications of the individuals caring for the child, and reporting to the RCY.
2. The ministry will increase the number of residential resources to address the gap in emergency placements, with priority to be given to those SDAs most frequently utilizing hotel placements.
3. The ministry will deliver its first public report on hotel placements on June 1, 2016.

Appendix A – Practice Directive

Program Area: Child Safety, Family Support and Children in Care Services Ministry of Children and Family Development	Practice Directive
Amendment Date:	Practice Directive # 2016-01

Hotel Placement for Children in Care

Directive Statement

Hotels are not appropriate living arrangements for children in care (CICs). Children in care may only be placed in hotels in exceptional circumstances for short durations approved by a designated director when no other appropriate resource is available.

Key Points

- A designated director must approve the decision to place a child in a hotel prior to the placement. Attempts should be made to obtain approval first from the designated director responsible for the Service Delivery Area (SDA) or Delegated Aboriginal Agency (DAA) in which the child's file is managed. If the responsible designated director cannot be contacted in a timely way, another designated director, including the Provincial Director of Child Welfare, may provide approval.
- The designated director responsible for the SDA or DAA in which the child's file is managed must monitor the CIC placed in a hotel and inform the Provincial Director of Child Welfare of the circumstances.
- When a child is placed in a hotel, the delegated worker must update the child's location on the Child Service file in ICM at the start and end of the hotel placement.

- Every CIC placed in a hotel must be cared for by a delegated social worker or caregiver who is assessed, approved and trained according to the *Caregiver Support Service Standards* or, in the case of a contractor, policies for *Approving Caregivers hired by Contracted Agencies*.
- In this Practice Directive, the term “hotel” is inclusive of motels, bed and breakfasts or any other short term lodging commercially available to the general public.
- This Practice Directive applies to all CICs, including those on an Independent Living Agreement. However, it does not apply to CICs in the following circumstances:
 - a CIC is staying in a hotel while travelling with a caregiver
 - a CIC is staying in a hotel as a part of an experience related to a school field trip or extracurricular sport activity
 - a CIC is staying in a hotel that serves as accommodations related to the CIC’s employment (e.g. work camp)
 - a CIC independently checks into a hotel without the approval or support of a director (e.g. AWOL or runaways).
- This Practice Directive does not apply to youth on a Youth Agreement or other out of care living arrangements under the *Child, Family and Community Service Act* (CFCSA).

Directive Information

- A delegated worker obtains approval from a designated director prior to placement of a CIC in a hotel by:
 - submitting a completed Hotel Placement Form via email to the designated director and receiving written approval from the designated director via email response; or
 - if circumstances necessitate only a verbal approval from a designated director, submission of the Hotel Placement Form and receipt of written approval to occur within 24 hours.
- Ensure that each CIC’s placement in a hotel is always documented in ICM (refer to the appendix to this Practice Directive regarding how to document a hotel placement in ICM). Responsibility for ensuring up to date electronic documentation belongs, in the following order, to:
 - The delegated worker who placed the child in the hotel (on the day of placement into a hotel, with the assistance of After Hours/Centralized Screening for ICM entry if necessary)
 - The guardianship worker for the child; and
 - The designated director with responsibility for the respective SDA or DAA in which the child’s file is managed.
- When a CIC is placed in a hotel, the rights of CICs as set out in the CFCSA and the guardianship responsibilities of the director as set out in policy continue to apply.

- For the duration of a CIC's stay in a hotel, a delegated worker must:
 - assess the hotel accommodations and care arrangements to ensure that the quality of care and supervision is appropriate to the child's needs
 - provide the caregiver with all relevant information about the child's needs
 - meet with the child and caregiver every day until the child is moved to an appropriate resource and provide any immediate supports that are needed
 - ensure that the caregiver is caring for no more than one child or, if the children are a sibling group, no more than three children
 - contact the designated director every day to:
 - provide an update on the child's safety and well-being
 - provide an update on the plan to move the child to a resource; and,
 - obtain approval for the child to remain in the hotel.
 - respond to any emergent issues as identified by the child or the caregiver and reporting these to the designated director.
- The designated director informs the Provincial Director of Child Welfare in writing of the child's initial placement in the hotel within 24 hours of the placement and on each subsequent day of the hotel placement. Information provided includes:
 - the completed Hotel Placement Form; and
 - any updates related to:
 - the child's well-being
 - the care arrangements for the child, including any supports provided
 - efforts and plans to move the child to a resource; and,
 - the date the child is moved to a resource.
- The Provincial Director of Child Welfare:
 - tracks and monitors each hotel placement, including the duration
 - notifies the Representative for Children and Youth if a child has been placed in a hotel for 3 days. The following information is provided to the Representative for Children and Youth:
 - the completed Hotel Placement Form, and
 - any updates related to:
 - the date the child was placed in the hotel
 - the care arrangements for the child, including any supports provided
 - the child's well-being
 - the plan to move the child to a resource
 - any other information requested by that office; and,
 - the date the child is moved to a resource.

Appendix B – Adding a Location/Placement in ICM

- Step 1 Navigate to the Child Service Case
- Step 2 Navigate to the Location/Placement view tab
- Step 3 Highlight the Child in the Involved Family Members applet
- Step 4 Scroll to the Location Placement History applet
- Step 5 Click the Add Location button
- Step 6 Select "Hotel/Motel" as the Location Type from the drop down menu
- Step 7 Type Name of the Hotel in the field
- Step 8 Enter Start Date in the field
- Step 9 Enter Apartment number (or hotel room number) and Address
in the corresponding fields
- Step 10 Scroll down and enter the reason for the hotel placement in the Comment text box
- Step 11 Ctrl+Shift+S to save the location record

References

Relevant legislation, policies, standards, literature

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Manitoba Family Services. *Child and Family Services Standards Manual 1.4.3*. Use of Hotels. (2015). Retrieved from <http://www.gov.mb.ca/fs/cfsmanual/1.4.3.html>

Contact Information

Representative for Children and Youth

Phone

In Victoria: 250-356-6710
Elsewhere in B.C.: 1-800-476-3933

E-mail

rcy@rcybc.ca

Fax

Victoria: 250-356-0837
Prince George: 250-561-4624
Burnaby: 604-775-3205

Website

www.rcybc.ca

Offices

400 – 1019 Wharf Street
Victoria, B.C. V8W 2Y9

1475 10th Avenue
Prince George, B.C. V2L 2L2

#150 4664 Lougheed Highway
Burnaby, B.C. V5C 5T5



B.C.'s Representative
for Children and Youth



@rcybc or @rcybeyouth



Rep4Youth

Ministry of Children and Family Development

Phone

In Victoria: 250-387-7027
Elsewhere in B.C.: 1-877-387-7027

E-mail

MCF.CorrespondenceManagement@gov.bc.ca

Fax

250-356-5720

Website

www.mcf.gov.bc.ca

Offices

To locate an office in your area, please visit:
www.mcf.gov.bc.ca/sda/contacts.htm#ef

Scheffel, Emile HLTH:EX

From: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Sent: Wednesday, January 13, 2016 1:20 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Follow Up Flag: Follow up
Flag Status: Flagged

Thanks Emile!

He will be travelling at that time so it would be great if he can call into a conference call line. Can you please confirm who will be on the call?

Elizabeth

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 13, 2016 12:31 PM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Subject: Re: Questions from MLA Simons

We have a winner!

Does your office have a t/c line you'd like to use? If not, we can provide one.

From: Parkinson, Elizabeth
Sent: Wednesday, January 13, 2016 11:46 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Hi Emile,

January 29th at 4:30 pm would work for MLA Simons.

Thanks,

Elizabeth

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 13, 2016 11:29 AM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Subject: RE: Questions from MLA Simons

Unfortunately the relevant staff will be in Vancouver for meetings that day. They have suggested that the following would work by teleconference – would any of them work for you?

Jan 19
Jan 22 in the am
Jan 29 in the pm.

MLA Simons will be in Victoria on January 21st. Can you please advise if that date would work for your staff?

Thanks,

Elizabeth

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 12, 2016 10:09 AM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Subject: RE: Questions from MLA Simons

Good morning Elizabeth,

We will be happy to make our director of maternal health available – could you let me know a few dates and times in the next couple of weeks that would work on your end?

Thanks E

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]
Sent: Monday, January 4, 2016 3:01 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Thank you Emile.

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 4, 2016 3:00 PM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Cc: Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Subject: RE: Questions from MLA Simons

Thanks Elizabeth. I have asked staff to indicate availability.

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]
Sent: Monday, January 4, 2016 2:59 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Thanks Emile. I believe this is about financial coverage for hearing aids for children. Apparently the Lions Club used to help families, but is now unable to provide families that financial assistance.

Elizabeth

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 4, 2016 2:55 PM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Cc: Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Subject: RE: Questions from MLA Simons

Hi Elizabeth,

We'd be happy to set this up.

Is there any more specific info I can pass along to staff to assist them in preparing?

Good afternoon Emile,

MLA Nicholas Simons has asked me to set-up a call or meeting with MoH staff regarding questions he has about children's hearing aids. Can you please confirm a time this would be possible?

Best regards,

Elizabeth Parkinson | Legislative Assistant |

New Democrat Official Opposition Caucus

T: 250.387-1665 | F: 250.387.4680

elizabeth.parkinson@leg.bc.ca | www.bcndpcaucus.ca

CORE MESSAGING

Updated: September 2015

Ministry of Health

END-OF-LIFE CARE SUPPLEMENT

- In addition to our Provincial End-of-life Care Action Plan for British Columbia, we are committed to double the number of hospice spaces in the province by 2020.
- Health authorities are working to meet that mandate.
- There will be 375 additional hospice spaces, which include dedicated and designated beds and home-based palliative care services in communities across the province.
- 61 beds are proposed for future roll out in each health authority, starting in April 2015, as follows:
 - Fraser Health: 15 beds
 - 10 beds at Holmberg House in Abbotsford (April 2016)
 - 5 beds at Peace Arch Hospice in White Rock (2018/19)
 - Vancouver Coastal Health: 12 beds
 - to be owned and operated by Providence Health care
 - Island Health: 24 beds
 - 8 beds in Comox and Parksville by Fall 2015
 - 3 beds in Campbell River (2016/17)
 - 2 beds in Sooke (2016/17)
 - 4 beds in Cowichan Valley (2017/18)
 - 1 bed in Mt. Waddington (2017/18)
 - 2 beds in Comox Valley (2018/19)
 - 1 bed in Oceanside (2018/19)
 - An additional 11 beds – location to be determined (2019/20)

- Interior Health:
 - Work is underway to determine strategies for optimizing Interior Health's existing bed stock to meet the needs of their rural and remote regions where stand-alone hospices have proved inefficient due to community size.
 - Based on current and projected growth, 30 locations have been identified as needing designated or dedicated beds.
- Northern Health: 10 beds
 - 2 in the Northeast
 - 4 in the Northwest
 - 4 in the Northern Interior

CORE MESSAGING

Updated: September 2015

Ministry of Health

END-OF-LIFE CARE

- Premier Clark has given me a mandate to improve palliative and end-of-life care by building hospice capacity and partnering with those who support the health care system, and this important work is underway.
- Availability of palliative and end-of-life care becomes increasingly important as the population grows and ages.
- In future, the challenge of providing critical care services will become greater due to increasing numbers of people dying, increasing age of family caregivers and decreasing number of available caregivers.
- Our goal is to double the number of hospice spaces in B.C. by 2020.
- The ministry released the *Provincial End-of-life Care Action Plan for British Columbia* in March 2013. It was developed in consultation with clinical experts, community stakeholders, policy leaders and service providers and identifies three priority areas: delivery of timely co-ordinated end-of-life care; provision of education tools and resources to patients, caregivers and health care providers; and strengthening accountability and efficiency.
- At the same time, government, through the Provincial Health Services Authority, provided \$2 million to establish the BC Centre for Palliative Care.
- The centre is accelerating innovation and best practice in end-of-life care for people with life limiting illnesses by focusing on improving access to palliative care supports, enabling excellence through support for health professionals, and mobilizing citizen engagement to promote compassionate communities.
- In 2011, B.C.'s laws for incapacity planning changed to give capable adults more options to make their wishes for future health care known – including end-of-life care – by naming a representative and/or making an advance directive without needing to visit a lawyer or notary public.

- In 2012, the ministry led the implementation of advance care planning and advance directives in the province, and is currently working with the BC Centre for Palliative Care to refine the guide and develop tools and resources to facilitate their use.

Facts about End-of-life Care

- We know most people would prefer to spend their final days at home with friends and family around them. In 2014, about 56% of people who died of natural causes in B.C. spent their final days at home, in residential care or in hospice (compared to about 44% in 2003).
- The baseline measure for hospice spaces is 375 beds. As of March 2015, it consists of 87 acute/tertiary palliative care unit beds and 288 community hospice beds.
- Hospice spaces also include home-based palliative care services for those individuals who wish to die at home. Baseline measures and targets are being established.
- B.C. Palliative Care Benefits support B.C. residents who choose to die at home with the same drug coverage they would receive if they were in hospital, and with the necessary supplies and equipment.
- Approximately 88,000 patients have received these benefits since the program started in 2001. In 2014/15, \$17.5 million was spent on medications and pharmacy dispensing fees, up from \$3.9 million in 2001/02.
- We offer joint training for doctors and other health care professionals in palliative care. We also offer incentive payments to family physicians caring for patients with palliative needs.
- HealthLink BC also provides an after-hours palliative service, which provides triage and support to palliative care patients who are being cared for at home.
- End-of-life care is also identified as a priority under the Primary Health Care Charter.

Investment in hospice:

In 2015, we provided funding of:

- \$2.5 million to the Abbotsford Hospice Society to support the completion of Holmberg House, a new adult hospice.

In 2014, we announced funding of:

- \$40,000 to the North Thompson Valley Hospice House Society to conduct a feasibility study to develop hospice care.
- \$250,000 to the St. Joseph's Hospital Foundation to support four new hospice beds in Comox.
- \$40,000 to the Oceanside Hospice Society to help support end-of-life care services.

In 2013, we announced funding of:

- \$950,000 to Vancouver Hospice Society to allow the new hospice home to become fully operational.
- \$2 million to support a new, permanent home for Marion Hospice in Vancouver.
- \$2 million to Canuck Place Children's Hospice
- \$3 million for the expansion of Peace Arch Hospice in White Rock.

In 2012, we announced funding of:

- \$1.5 million to Canuck Place Children's Hospice

In 2011, we announced funding of:

- \$3.5 million to the Abbotsford Hospice Society

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 8:18 AM
To: Scheffel, Emile HLTH:EX
Cc: Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Subject: Re: CCS palliative care study

Thanks. Let's get a tweet for the PG hospital letter too.

Terry Lake DVM
Minister of Health

On Jan 12, 2016, at 8:12 AM, "Scheffel, Emile HLTH:EX" <Emile.Scheffel@gov.bc.ca> wrote:

Morning Minister,

KMs attached in case you get a question on this CCS study today.

I read through it, there is no specific mention of BC and only Quebec is singled out for praise as they have a legislated obligation to provide palliative care to cancer patients.

Will share with PCC crew as well.

E

From: tno@gov.bc.ca
Sent: Tuesday, January 12, 2016 7:45 AM
Subject: CBCV: Miller - palliative care

CBCV (CBC Victoria)
CBC On the Island
12-Jan-2016 06:49

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TNO...

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<End-of-life care - Sept 2015_CM.docx>

<End-of-Life Care Supplemental - Sept 2015_CM.docx>

Scheffel, Emile HLTH:EX

From: Docs Processing HLTH:EX
Sent: Tuesday, January 12, 2016 8:12 AM
To: Dhanowa, Damon HLTH:EX
Cc: HLTH Ministers Office; Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Subject: 5 NEW NAMING OPPORTUNITIES (CLIFF 1046672)

Hi Damon:

The Manager of Appointments and Operations, IGR - Laverne Bennett - has advised that the process for naming opportunities is a little complex. The process/policy is administered by the Ministry of Technology, Innovation and Citizens' Services (MTICS) on behalf of Government. When MTICS receives an application, they complete their review and once they are OK with the application they forward to the appropriate Ministry and to the Naming Committee (a committee established by MTICS composed of executives from various Ministries). The Ministry of Health reviews and completes its due diligence and once we have confirmed no issues, Laverne advises appropriate staff within the Ministry including Doc's Processing and MTICS. Doc's Processing then notifies the Minister's office.

At this point, the Naming Committee may or may not have completed their review and until each of the Committee Members has confirmed that they have no issues with the proposed naming opportunity, nothing is released to the applicant or the Minister(s). Although the Ministry may not have found issues with the naming opportunity, the members on the Naming Committee may have issues or questions they need to have answered before they can provide their decision. This process could take months to finalize. Once MTICS hears from us and the Naming Committee that there are no issues with the naming opportunities, it is MTICS that notifies the applicant, not the Ministry of Health. In addition, Cabinet had previously requested MTICS to provide a report to them once a year on those naming opportunities that did not require Cabinet approval (those that are under \$5 million or that might have unusual circumstances that the Naming Committee or the Ministry had asked specifically that it go to Cabinet for consideration). The last report to Cabinet was December, 2015, so MTICS does not expect another report to Cabinet until next fall at the earliest.

It would be premature for the Ministry of Health to release any information relating to these naming opportunities until MTICS confirms the Naming Committee supports the opportunities and that they (MTICS) had notified the applicant.

If you have any questions or wish to discuss this process, please call Laverne at 250-952-1048.

Hope this helps.

Thanks so much,

Kathy Simonson
Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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From: Dhanowa, Damon HLTH:EX
Sent: Monday, January 11, 2016 3:21 PM
To: Docs Processing HLTH:EX; HLTH Ministers Office
Cc: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX

Cc: Andrachuk, Andrea HI TH•FX• Docs Processing HI TH•FX
Subject: 5 NEW NAMING OPPORTUNITIES (CLIFF 1046672)

Hi All:

Program staff have advised that the attached approved naming opportunities are being provided to you as FYI only.

Ministry staff has reviewed with no concerns raised. As the donation in each of these naming opportunities is less than \$5 million, these Naming Opportunities will not be going forward to Cabinet for approval.

Thanks so much,

Kathy Simonson

Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health

5-3 1515 Blanshard St. Victoria BC V8W 3C8

Telephone 250 952-6998

kathy.simonson@gov.bc.ca

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Scheffel, Emile HLTH:EX

From: James, Ben <Ben.James@leg.bc.ca>
Sent: Tuesday, January 12, 2016 8:31 AM
Subject: News You Can Use: Land-Based Spill Response for Hazardous Substances
Attachments: NR_World-leading land-based spills_June 15_2015_FINAL.PDF

News You Can Use: Land-Based Spill Response for Hazardous Substances

In light of yesterday's announcement informing British Columbians that Kinder Morgan has failed to meet government's Five Conditions including around its proposed spill prevention, there have been enquiries about B.C.'s hazardous substance land-based spill system. Below is messaging and attached is the news release and backgrounders from last June's announcement about the new system.

Lead: Ministry of Environment

Key Messages:

- B.C.'s new spill response regime will ensure an effective response to any land-based spill of any hazardous substance, from any source.
- These new requirements take into account over two years of engagement with industry, First Nations and local governments.
- The key elements of the new regime include:
 - A provincially certified, industry-funded Preparedness and Response Organization (PRO) to make sure trained people are ready to immediately respond to any spill, with appropriate equipment and in a coordinated way.
 - New legislative and regulatory requirements for spill preparedness, response and recovery.
 - Geographically-based planning and response that will see active participation by First Nations, first responders and local communities.
- B.C.'s new system will also complement marine response capabilities and if it is necessary to support a federal marine response, the new system will help with response coordination and minimize potential impacts to shorelines.
- The new system, including detailed regulations is expected to be in place beginning in 2017.

Attachment: News Release and Backgrounders

*Ben James
Director of Communications
BC Liberal Government Caucus
250-356-9131 (office)
250-208-7052 (mobile)*

Scheffel, Emile HLTH:EX

From: Thornthwaite, Jane <J.Thornthwaite@leg.bc.ca>
Sent: Tuesday, January 12, 2016 10:16 AM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: FW: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hello Minister. Happy New year!

Just wondering if there is an agenda of this meeting and if Child and Youth Mental Health (or Mental Health in general) is on it. I know that there is a generic high level reference to mental health services in the Federal Health Minister's mandate letter, but I'm wondering if a national program (or provincial transfer funding for mental health initiatives) like Australia's HeadSpace model is being talked about plus a plan for First Nations youth either on or off reserve.

In either case, I'm interested to see how far up this issue is on federal minds.

Thank you so much

Jane

From: Government of British Columbia [<mailto:GCPE.News@gov.bc.ca>]
Sent: January 12, 2016 8:54 AM
To: GCPEMINIS@gov.bc.ca
Subject: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Jan. 12, 2016

MEDIA ADVISORY - Federal, provincial and territorial Health Ministers

VANCOUVER - The Honourable Jane Philpott, Canada's Minister of Health, and the Honourable Terry Lake, British Columbia's Minister of Health, will co-chair a meeting of federal, provincial and territorial Health Ministers in Vancouver, B.C., January 20 and 21.

Please note all details are subject to change. All times are local Pacific time. Media teleconference details to be provided at a later date.

DATES:

On January 20, Minister Lake will host provincial and territorial Health Ministers, while both Ministers Philpott and Lake will co-chair the meeting on January 21.

TIMES:

Wednesday, January 20, 2016 - Provincial-territorial Health Ministers' meeting

7:30 a.m. - Media registration opens

8:30 a.m. - Photo opportunity with Ministers prior to start of meeting

3:15 p.m. - News conference with provincial and territorial Health Ministers

All media events will be held at the Fairmont Hotel Vancouver
900 West Georgia Street
Vancouver, B.C.

Media who wish to attend must register upon arrival and obtain
accreditation by presenting press identification at the Saturna
Island Room.

CONTACTS:

Media Relations
B.C. Ministry of Health
250 952-1887

Media Relations
Health Canada
613 957-2983

Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 10:12 AM
To: Plank, Sarah GCPE:EX
Cc: Scheffel, Emile HLTH:EX; Thistle-Walker, Carlene GCPE:EX; Dhanowa, Damon HLTH:EX
Subject: Event materials

Hey Sarah,

Can we ensure that the Minister's speaking notes include an itinerary for the event? Today's was missing and he commented about it.

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

Scheffel, Emile HLTH:EX

From: Marr, Ann HLTH:EX
Sent: Tuesday, January 12, 2016 10:12 AM
To: Scheffel, Emile HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: RE: HMM - air ambulance

No problem. Appreciate receiving any intel you receive along the way to ensure it is covered off.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:09 AM
To: Marr, Ann HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: RE: HMM - air ambulance

Perfect thanks – and please forgive my poor info retention as I pull double duty over here ☺

E

From: Marr, Ann HLTH:EX
Sent: Tuesday, January 12, 2016 10:09 AM
To: Scheffel, Emile HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: RE: HMM - air ambulance

s.16

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:55 AM
To: Marr, Ann HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: HMM - air ambulance

Morning,

I had a chat with my Ontario counterpart today, and he mentioned they'll be doing a little bit of media on their goals and priorities for HMM.

The one thing we should be aware of is that Minister Hoskins may raise the issue of air ambulance coverage between provinces, as a follow up to this case: <http://www.cbc.ca/news/canada/sudbury/ontario-alberta-to-split-air-ambulance-cost-for-out-of-province-claim-1.3195929>

Thanks E

Scheffel, Emile HLTH:EX

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 10:09 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: e-Prescribing

Perfect.

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:45 AM
To: Michell, Jennifer HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: e-Prescribing

Sounds good thx, will let him know.

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 9:39 AM
To: Scheffel, Emile HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: e-Prescribing

If we can have this conversation occur right after the CCST briefing as Deb Shera will be on the phone for this meeting that would be ideal as she is well versed in ePrescribing.

Thanks so much
Jen

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:29 AM
To: Michell, Jennifer HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Stearn, Anne HLTH:EX
Subject: RE: e-Prescribing

Way better idea – thanks.

I will let him know that Sabine can give him a quick update this afternoon.

E

Sabine is actually meeting in person with the Minister this afternoon on two other items. Perhaps they can connect following one of those briefings? She has one from 1:30-2 and the other from 2:15-2:45

Jennifer Michell

Manager, Corporate Services

Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX

Sent: Tuesday, January 12, 2016 9:13 AM

To: Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX

Cc: Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX

Subject: e-Prescribing

Good morning!

MTL asked that I share the below article and check in for an update on e-Prescribing.

Does one of you have a few minutes later today?

Many thanks,

E

Island Health launches paperless record system in Nanaimo

Nanaimo News Bulletin

Monday, January 11, 2016

Page 4

By Tamara Cunningham

Copyright

Scheffel, Emile HLTH:EX

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 10:07 AM
To: Scheffel, Emile HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Hi Emile,

Yes, staff have provided the below names for the conversation with MLA Simons. Would it be best to work through you to confirm a time with MLA Simons' office? If he provides a few options then we can get everyone on a teleconference.

PPH attendance will be:

- Tamil Kendall – Director, Maternal Health, Public Health Services Branch, Population and Public Health Division
- 250-952-3678, Tamil.Kendall@gov.bc.ca
 - Tamil also would like to extend the invite to:
 - Janice Linton, from HSP as she is the Director responsible for PHSA; and
 - Melanie Foster, Senior Policy Analyst working on early childhood health.

Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:46 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Just checking in on this one ☺

From: Scheffel, Emile HLTH:EX
Sent: Thursday, January 7, 2016 9:42 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Hi there!

Any sense of who/when might be able to connect with MLA?

We'd like to have someone from MO participate.

Thanks! E

From: Andrachuk, Andrea HLTH:EX
Sent: Monday, January 4, 2016 3:52 PM
To: Scheffel, Emile HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Monday, January 4, 2016 2:56 PM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: FW: Questions from MLA Simons

Hey folks,

Hoping that MBPSD can make someone available for this in the next couple of weeks – could you please advise?

I have asked for more specific info.

Thanks E

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]
Sent: Monday, January 4, 2016 2:54 PM
To: Scheffel, Emile HLTH:EX
Subject: Questions from MLA Simons

Good afternoon Emile,

MLA Nicholas Simons has asked me to set-up a call or meeting with MoH staff regarding questions he has about children's hearing aids. Can you please confirm a time this would be possible?

Best regards,

Elizabeth Parkinson | Legislative Assistant |
New Democrat Official Opposition Caucus
T: 250.387-1665 | F: 250.387.4680
elizabeth.parkinson@leg.bc.ca | www.bcndpcaucus.ca

Scheffel, Emile HLTH:EX

From: Steve Vander Wal <Steve.VanderWal@hkstrategies.ca>
Sent: Tuesday, January 12, 2016 10:05 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Meeting Request - Innovation Arthritis Triage

Thanks very much Emile. We heard from the ADM's office this morning.

-----Original Message-----

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: Tuesday, January 12, 2016 9:39 AM
To: Steve Vander Wal <Steve.VanderWal@hkstrategies.ca>
Subject: Re: Meeting Request - Innovation Arthritis Triage

Hey Steve I'm told a meeting is in the works for early Feb. Let me know if you need anything else.

Thanks E

From: Steve Vander Wal
Sent: Monday, January 11, 2016 10:30 AM
To: Scheffel, Emile HLTH:EX
Subject: FW: Meeting Request - Innovation Arthritis Triage

FYI - note sent to ADM Doug Hughes' office. any assistance to help keep this on track appreciated. I didn't mention Kevin's meeting with you directly though it is referenced at the bottom of the email. Thanks in advance.

From: Steve Vander Wal
Sent: Monday, January 11, 2016 10:29 AM
To: 'Carol.hoyer@gov.bc.ca' <Carol.hoyer@gov.bc.ca>; 'tamara.casanova@gov.bc.ca' <tamara.casanova@gov.bc.ca>
Cc: Kevin Harrington (Kevin.Harrington@abbvie.com) <Kevin.Harrington@abbvie.com>
Subject: FW: Meeting Request - Innovation Arthritis Triage

Carol and Tamara - Dr. Kam Shojania and Kevin Harrington look forward to meeting with ADM Doug Hughes to discuss and innovative care model to improve arthritis patient outcomes (one of the top chronic diseases in BC) while reducing system costs.

Attached is a presentation that outlines Dr. Shojania's innovative proposal to develop and utilize a qualified online triage tool to deliver better, more efficient and cost-effective arthritis care in BC.

I understand ADM Hughes' time is in high demand but I can assure you this innovative proposal aligns well with the government's priorities related to more efficient use of physician resources, better rural access to care and reduced waiting times.

Given the work ahead they hope the meeting can happen in the coming weeks so please let us know about availability. Thanks!

From: Crisp, Leah HLTH:EX [mailto:Leah.Crisp@gov.bc.ca]
Sent: Monday, January 11, 2016 10:10 AM
To: Steve Vander Wal <Steve.VanderWal@hkstrategies.ca><mailto:Steve.VanderWal@hkstrategies.ca>>
Cc: Crisp, Leah HLTH:EX <Leah.Crisp@gov.bc.ca><mailto:Leah.Crisp@gov.bc.ca>>
Subject: RE: Meeting Request - Innovation Arthritis Triage

Leah Crisp / Executive Assistant / Heather Davidson, Assistant Deputy Minister / Partnerships and Innovation Division /
Ministry of Health / Victoria BC / P: 250.952.2791 F: 250.952.2109 / email:
leah.crisp@gov.bc.ca<mailto:leah.crisp@gov.bc.ca>

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From: Steve Vander Wal [mailto:Steve.VanderWal@hkstrategies.ca]
Sent: Tuesday, January 5, 2016 11:24 AM
To: Crisp, Leah HLTH:EX
Subject: FW: Meeting Request - Innovation Arthritis Triage

From: Harrington, Kevin K [mailto:Kevin.Harrington@abbvie.com]
Sent: Wednesday, December 16, 2015 2:41 PM
To: doug.hughes@gov.bc.ca<mailto:doug.hughes@gov.bc.ca>; Heather Davidson
<heather.davidson@gov.bc.ca<mailto:heather.davidson@gov.bc.ca>>
Cc: Dr. Kam Shojania^{s.22} ; Carol D Hoyer
<Carol.Hoyer@gov.bc.ca<mailto:Carol.Hoyer@gov.bc.ca>>; lisa.clout@gov.bc.ca<mailto:lisa.clout@gov.bc.ca>;
leah.crisp@gov.bc.ca<mailto:leah.crisp@gov.bc.ca>
Subject: Meeting Request - Innovation Arthritis Triage

Dear Mr. Hughes & Ms. Davidson,

I understand there has been some recent discussion around consideration of the meeting request below, originally sent to Lynn Stevenson and Heather Davidson.

I wanted to reach out to let you know that Dr. Kam Shojania and I are available to come to Victoria next week, if you would be available to meet. We are excited to discuss an innovative arthritis care model for BC that will provide system efficiencies and important savings while improving patient access to appropriate care. We look forward to meeting with you both.

Please let me know if you require any information while you consider our request. We appreciate your consideration of this request.

Thank you,
Kevin

KEVIN HARRINGTON
Sr. Manager - Provincial Affairs & Health Policy British Columbia

From: Harrington, Kevin K [mailto:Kevin.Harrington@abbvie.com]
Sent: Thursday, December 10, 2015 11:20 AM
To: Lynn.Stevenson@gov.bc.ca<mailto:Lynn.Stevenson@gov.bc.ca>; Heather Davidson
(heather.davidson@gov.bc.ca<mailto:heather.davidson@gov.bc.ca>)
<heather.davidson@gov.bc.ca<mailto:heather.davidson@gov.bc.ca>>
Cc: Kam Shojania^{s.22}
s.22
Subject: FW: Meeting request - Arthritis Triage

In case there is room in your calendar the last week before the holiday, Dr. Shojania and I will reorganize our schedules to meet with you on either Monday Dec 21, Tuesday Dec 22 or Wednesday Dec 23. We would appreciate if can let us know if any of these dates can work.

Thank you,
Kevin

KEVIN HARRINGTON

Sr. Manager - Provincial Affairs & Health Policy British Columbia

From: Harrington, Kevin K

Sent: December-02-15 4:22 PM

To: Lynn.Stevenson@gov.bc.ca<mailto:Lynn.Stevenson@gov.bc.ca>; Heather Davidson
(heather.davidson@gov.bc.ca<mailto:heather.davidson@gov.bc.ca>)

Cc: Kam Shojania s.22

Subject: Meeting request - Arthritis Triage

Lynn and Heather - I am following up on a conversation that I had with Emile Scheffel in Minister Lake's office regarding an innovative care model to improve arthritis patient outcomes (one of the top chronic diseases in BC) while reducing system costs and he suggested that I book a meeting with you. Attending would be Dr. Kam Shojania, Clinical Professor and Head, Division of Rheumatology UBC and myself. I have included his contact information at the bottom of this email. We would like to discuss Dr. Shojania's innovative proposal to develop and utilize a qualified online triage tool to deliver better, more efficient and cost-effective arthritis care in BC (overview slides attached). We are able to travel to Victoria on Wednesday December 9th or Wednesday December 16th. If those dates don't work for you we can meet most other week days before or after regular business hours in Vancouver or Victoria.

As you know, there are very long waits to access a rheumatologist in BC (9 months to 1 year) though clinical practice guidelines strongly suggest most arthritis patients do not need to see a specialist. Access for patients with rheumatoid arthritis particularly those in rural BC can be especially challenging given the majority of the 64 rheumatologists in the province are located in Metro Vancouver. Also, arthritis costs for BC have been rising steadily due to hip and knee surgeries for osteoarthritis and delays in access to appropriate drug therapy to effectively treat rheumatoid arthritis (and related forms inflammatory arthritis).

I look forward to your reaction and welcome any questions you might have.

Thank you,

Kevin

KEVIN HARRINGTON

Sr. Manager - Provincial Affairs & Health Policy British Columbia <image001.png> AbbVie Corporation

OFFICE 604-929-9155<tel:604-929-9155>

CELL 604-417-5280<tel:604-417-5280>

EMAIL kevin.harrington@abbvie.com<mailto:david.link@abbvie.com>

abbvie.com<http://www.abbvie.com/>

Kam Shojania, MD, FRCPC

Clinical Professor and Head,

Postgraduate Program Director,

Division of Rheumatology

University of British Columbia

#802 - 1200<tel:802%20-%201200> Burrard Street Vancouver, BC Canada V6Z 2C7 t:604-806-9400<tel:604-806-9400>

f:604.269-3736

email: DUPLICATE

www.ubcrheumatology.com<http://www.ubcrheumatology.com/>

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Scheffel, Emile HLTH:EX

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 9:39 AM
To: Scheffel, Emile HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: e-Prescribing

If we can have this conversation occur right after the CCST briefing as Deb Shera will be on the phone for this meeting that would be ideal as she is well versed in ePrescribing.

Thanks so much
Jen

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:29 AM
To: Michell, Jennifer HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Stearn, Anne HLTH:EX
Subject: RE: e-Prescribing

Way better idea – thanks.

I will let him know that Sabine can give him a quick update this afternoon.

E

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 9:27 AM
To: Scheffel, Emile HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Stearn, Anne HLTH:EX
Subject: RE: e-Prescribing

Hi Emile

Sabine is actually meeting in person with the Minister this afternoon on two other items. Perhaps they can connect following one of those briefings? She has one from 1:30-2 and the other from 2:15-2:45

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:13 AM
To: Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX
Cc: Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX

Many thanks,

E

Island Health launches paperless record system in Nanaimo

Nanaimo News Bulletin

Monday, January 11, 2016

Page 4

By Tamara Cunningham

Copyright

Scheffel, Emile HLTH:EX

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 9:38 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hi Emile,

Doug's team has now been in communication with Steve Vander Wal (he assists Dr. Shojania & Kevin Harrington with their calendars). It sounds like they are looking for a time to meet in early February now.

Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Monday, January 11, 2016 10:32 AM
To: Andrachuk, Andrea HLTH:EX
Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hi Andrea,

Happy Monday – following up on this as the stakeholder is following up with me.

Thanks E

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 5, 2016 11:32 AM
To: Andrachuk, Andrea HLTH:EX
Cc: Merrifield, Katy HLTH:EX
Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hi Andrea,

Do you know where this landed?

Just chatted with the stakeholder, and they would be happy to do a preliminary meeting below Doug's level to help move this forward. Preference is definitely in January.

Thanks E

From: Andrachuk, Andrea HLTH:EX
Sent: Thursday, December 10, 2015 3:25 PM
To: Scheffel, Emile HLTH:EX
Cc: Merrifield, Katy HLTH:EX
Subject: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hi Emile,

We have determined that this would be through Doug's area. I have asked his office to contact them. Have you got an email for Kevin Harrington or Dr. Shojania?

From: Scheffel, Emile HLTH:EX

Sent: Tuesday, December 1, 2015 5:18 PM

To: Stevenson, Lynn HLTH:EX; Walman, Barbara J. HLTH:EX; Hughes, Doug J HLTH:EX; Davidson, Heather (ADM) HLTH:EX

Cc: Merrifield, Katy HLTH:EX; Foran, Grace E HLTH:EX; Andrachuk, Andrea HLTH:EX

Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Sorry for the second email – I meant to include Heather the first time.

E

From: Scheffel, Emile HLTH:EX

Sent: Tuesday, December 1, 2015 5:17 PM

To: Stevenson, Lynn HLTH:EX; Walman, Barbara J. HLTH:EX; Hughes, Doug J HLTH:EX

Cc: Merrifield, Katy HLTH:EX; Foran, Grace E HLTH:EX; Andrachuk, Andrea HLTH:EX

Subject: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hey folks,

I spoke today with Kevin Harrington of AbbVie, who took me through the attached slide deck proposing a new system to better triage arthritis patients and make better use of the available rheumatologists.

It is supported by Dr. Kam Shojania of the UBC rheumatology division.

I am hoping we could get your take on it, and that one or more of you might make yourselves available to hear from Kevin/Dr. Shojania directly.

Lynn, I think Kevin will also be getting in touch with you.

Many thanks in advance,

E

Scheffel, Emile HLTH:EX

From: Health eApprovals HLTH:EX
Sent: Tuesday, January 12, 2016 8:59 AM
To: Perez De Tagle, Michael HLTH:EX
Subject: eApproval issues - Error Message

Importance: High

Hi everyone,

Please note, some eApproval users are experiencing intermittent issues and receiving the error messages below. This issue is unfortunately a performance issue with the server at the SSBC end. The issue has been reported but generally resolves itself when the Server resumes.

If you are experiencing issues, exit out of the system and try again in 10 minutes or so.

MY ACTIVE ITEMS

Unable to display this Web Part. To troubleshoot the problem, open this Web page in a Microsoft SharePoint Foundation-compatible

Correlation ID:8c7077f6a-c5e9-460c-8ec7-76197bd4b6b2

RELATED DOCUMENTS

Unable to display this Web Part. To troubleshoot the problem, open this Web page in a Microsoft SharePoint Foundation-compatible HTML editor such as Microsoft SharePoint Designer. If the problem persists, contact your Web server administrator.

Correlation ID:8c7077f6a-c5e9-460c-8ec7-76197bd4b6b2

Unable to display this Web Part. To troubleshoot the problem, open this Web page in a Microsoft SharePoint Foundation-compatible HTML editor such as Microsoft SharePoint Designer. If the problem persists, contact your Web server administrator.

Correlation ID:8aafc75e-d257-41b6-b36f-c24cfbd93a30

Thanks,

Michael Perez de Tagle

Correspondence and Information Services Analyst | Correspondence and Documents Management | Ministry of Health | 1515 Blanshard Street, Victoria, BC, V8W 3C8 | Phone: 250.952.2474

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Personalized Onco-Genomic Cancer Research Announcement

"Leading the way in Cancer Research"

BC Cancer Agency Research Centre
675 West 10th Avenue

Date: Tuesday, January 12th, 2016 **Arrival Time:** 9:45 AM
Podium: Yes; **Dress:** Business
Sign: Leading the way in Cancer Research

Event Summary: Premier to announce funding to the BC Cancer Foundation to support personalized onco-genomic cancer research.

Action/Visual: Premier and Minister Lake to tour the BC Cancer Agency Research Lab and then proceed to the event space to make the announcement. The backdrop during the media avail will be made up of a 60" screen with looping images, and research staff in lab coats standing in front of BC flags.

Venue Audience: Doctors, research staff, donors and stakeholders

MLAs attending: Minister Lake (emcee)

Additional VIP's: Greg D'Avignon, Chair, BC Cancer Foundation; President & CEO, BCBC
Dr. Malcolm Moore, President BC Cancer Agency
Dr. Janessa Laskin, BC Cancer Agency
Dr. Marco Marra, BC Cancer Agency
Jennifer Strack, Patient enrolled in the POG treatment

Media Relations: Sam Oliphant / Mary Lo

Time	Event Itinerary
7:00 AM	AV Technical Set Up -- Tim on site
9:20 AM	Media arrives at the BC Cancer Agency and are directed to the event space on the main floor
9:20 AM	Dr. Laskin and Dr. Marra arrives at the main floor greenroom (Gordon and Leslie Diamond Theatre) for a rundown of the itinerary and proceed to the event space to begin the technical briefing
9:30 AM	Technical Briefing: Dr. Janessa Laskin and Dr. Marco Marra leads media in a technical briefing to discuss the details behind personalize onco-genomic cancer research
9:45 AM	Guests arrive; Speakers will be directed to the greenroom, Gordon and Leslie Diamond Theatre, on the main floor
9:45 AM	Premier arrives at the front entrance and is met by Tim Wong. The group departs to the greenroom for a pre-brief
9:48 AM Pre-Brief	Pre-brief led by Tim Wong with: - Premier - Minister Lake - Greg D'Avignon - Dr. Malcolm Moore - Jennifer Strack - Dr. Laskin - Dr. Marra Dr. Laskin will explain the patient enrollment process.
9:53 AM	Dr. Laskin and Dr. Marra lead the group to the 7 th floor to tour the lab
10:08 AM	Premier and the rest of the group proceed to the elevators to make their way to the announcement space
10:10 AM	Premier and Guest Speakers enter the event space and proceed to the podium - Guest Speakers will line up on the right side of the podium - Researchers with lab coats will line up behind the left side of the podium
10:11 AM	Minister Lake provides opening remarks and invites the Premier to the podium
10:13 AM	Premier delivers announcement

Events Coordinator – Tim Wong

Phone Number: 778-877-8596

Last updated: 2016-01-07 4:55 PM

Page 1 of 2

Personalized Onco-Genomic Cancer Research Announcement
“Leading the way in Cancer Research”
 BC Cancer Agency Research Centre
 675 West 10th Avenue

10:18 AM	Minister Lake thanks the Premier and invites Greg D’Avignon to the podium
10:19 AM	Greg D’Avignon delivers remarks
10:22 AM	Minister Lake thanks Greg and invites Dr. Malcolm Moore to the podium
10:23 AM	Dr. Malcom Moore delivers remarks
10:25 AM	Minister Lake thanks Dr. Moore and invites Jennifer Strack to the podium
10:26 AM	Jennifer Strack delivers remarks
10:28 AM	Minister Lake thanks Jennifer, delivers closing remarks and invites the Premier to the podium to hold a media availability
10:30 AM	Media Availability
10:40 AM	Photo-Op: Group shot with the Premier, guest speakers and research staff *Podium will be moved
10:45 AM	Premier departs
10:46 AM	Media are brought to the 7 th floor to capture b-roll footage - Only 2 cameras are allowed in the lab at a time

Contacts

Scheffel, Emile HLTH:EX

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 10:18 AM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX
Cc: Thistle-Walker, Carlene GCPE:EX
Subject: RE: Event materials
Attachments: Itinerary - January 12 - POG Cancer Research Announcement - Leading the Way in Cancer Research (2).pdf

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:14 AM
To: Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX
Cc: Thistle-Walker, Carlene GCPE:EX; Dhanowa, Damon HLTH:EX
Subject: RE: Event materials

Did he have the separate itin doc? Or does he just want that incorporated in the SN doc?

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 10:12 AM
To: Plank, Sarah GCPE:EX
Cc: Scheffel, Emile HLTH:EX; Thistle-Walker, Carlene GCPE:EX; Dhanowa, Damon HLTH:EX
Subject: Event materials

Hey Sarah,

Can we ensure that the Minister's speaking notes include an itinerary for the event? Today's was missing and he commented about it.

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

Scheffel, Emile HLTH:EX

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 10:51 AM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX; Docs Processing HLTH:EX
Subject: RE: Request - hospice spaces update

Hi Emile,
Yes, we'll get that for you.

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:48 AM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Subject: Request - hospice spaces update
Importance: High

Hi there,

Could I please get, by end of day tomorrow, a quick update on bed numbers and timelines for our mandate to double hospice beds by 2020? I have the below, dated Sept 2015.

If there has been a recent update or BN, mind sharing that as well?

Many thanks E

--

- In addition to our Provincial End-of-life Care Action Plan for British Columbia, we are committed to double the number of hospice spaces in the province by 2020.
- Health authorities are working to meet that mandate.
- There will be 375 additional hospice spaces, which include dedicated and designated beds and home-based palliative care services in communities across the province.
- 61 beds are proposed for future roll out in each health authority, starting in April 2015, as follows:
 - Fraser Health: 15 beds
 - 10 beds at Holmberg House in Abbotsford (April 2016)
 - 5 beds at Peace Arch Hospice in White Rock (2018/19)
 - Vancouver Coastal Health: 12 beds
 - to be owned and operated by Providence Health care
 - Island Health: 24 beds
 - 8 beds in Comox and Parksville by Fall 2015
 - 3 beds in Campbell River (2016/17)
 - 2 beds in Sooke (2016/17)
 - 4 beds in Cowichan Valley (2017/18)

- Interior Health:
 - Work is underway to determine strategies for optimizing Interior Health's existing bed stock to meet the needs of their rural and remote regions where stand-alone hospices have proved inefficient due to community size.
 - Based on current and projected growth, 30 locations have been identified as needing designated or dedicated beds.
- Northern Health: 10 beds
 - 2 in the Northeast
 - 4 in the Northwest
 - 4 in the Northern Interior

Scheffel, Emile HLTH:EX

From: Leake, Greg HLTH:EX
Sent: Tuesday, January 12, 2016 10:43 AM
To: Scheffel, Emile HLTH:EX
Subject: FW: AM Call

Emile:

FYI.

Participants: MTL/MO staff; S. Brown; P. Kendall; S. Pfank; G. Leake; and T. Lowe.

Flu Situation: PK confirmed that levels are currently low.

Naloxone/Drug Overdose: SP will continue to work with PHSA on a potential announcement for Friday (preferably in Vancouver) regarding firefighters carrying and administering naloxone. SP will touch base with MTL again tomorrow.

Vernon's Gartree Medical Clinic: MO staff confirmed that MLA Foster has been given messaging on reduced hours of operation.

E-Prescribing: MO staff to touch base with program staff re: launch of e-prescribing initiative.

G.

Greg Leake
Executive Director
Performance and Issues Management
Ministry of Health

Scheffel, Emile HLTH:EX

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 10:34 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: Quote Approval: Equipemnt for West Chilcotin

Good morning Minister – 2/2 with regard for quotes today. This NR is set to release on Thursday morning.
Thanks :D s.17

“Supporting primary care in rural and remote communities is a priority in our work to strengthen the health-care model for all British Columbians,” says Health Minister Terry Lake. “This medical equipment will help staff at the West Chilcotin Health Centre deliver high quality care closer to where their patients live and work.”

Medical equipment funding for clinic in B.C.’s wild, rugged and beautiful West Chilcotin

TATLA LAKE – The West Chilcotin Healthcare Society received \$50,000 from the Province for specialized equipment for their remote medical clinic. The clinic provides primary and interim emergency care to a tight knit community of 500 people.

“Supporting primary care in rural and remote communities is a priority in our work to strengthen the health-care model for all British Columbians,” says Health Minister Terry Lake. “This medical equipment will help staff at the West Chilcotin Health Centre deliver high quality care closer to where their patients live and work.”

This Interior Health clinic serves the regions of Kleena Klene, Puntzi, Chilko, Bluff, Sapeye, Tatla and Tatlayoko lakes. Dr. Robert Coetzee provides medical services at the West Chilcotin Health Centre, which is staffed by Ruth Kuehl-Venn a remote certified nurse and receptionist April Wright. With the nearest hospital three hours away by road in Williams Lake, the staff provide a wide variety of care daily, and emergency medicine as needed while ambulance support is on the way.

“The ranchers, loggers and old homesteader families of the West Chilcotin are an incredibly self-reliant community,” said Donna Barnett, MLA for Cariboo-Chilcotin. “Providing this equipment supports this independence, while ensuring medical staff have the right tools at their fingertips to provide medical care quickly and effectively.”

The government funds supplement the \$40,000 raised in the community over the past several years. Seeing a need to provide updated and specialized medical equipment for the community, residents and local businesses have come together to fundraise to buy medical equipment that they themselves or neighbours may need one day.

“For such a small community, we’ve had an overwhelming amount of support for the clinic; logging companies who work in the area, lodges and families have been incredibly generous,” said Dr. Mike Smialowski, retired physician and president of the society. “The purchases we have made and are making will exponentially increase the medical capabilities within in the community.”

In an area where house calls are a regular part of family practice Dr. Smialowski shares that in a community

To improve health care for British Columbians in every region of the province, the Ministry of Health has developed the overarching strategy, *Setting Priorities for the B.C. Health System*. As part of this, a series of policy papers – with a focus on primary and community care, rural health services and health human resources – were created to help guide the changes needed to build a better health system.

Scheffel, Emile HLTH:EX

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 10:34 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: Quote Approval - Post-secondary students learn about a healthier drinking culture

Good morning Minister – This NR is for release tomorrow afternoon after caucus releases go in the am. Thanks :Ds.17

“As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning,” said Lake. “Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person’s life can help set them on the right track.”

Post-secondary students learn about a healthier drinking culture

VICTORIA – Students at B.C. public post-secondary institutions will have access to additional supports to address substance use thanks to a \$400,000 investment for a project co-led by the Centre for Addictions Research of BC and the Canadian Mental Health Association BC Division, Health Minister Terry Lake announced today.

According to the 2013 National College Health Assessment Canadian survey, 26% of post-secondary students reported that the last time they socialized, they had seven or more drinks and 39% of students who drank alcohol in the last year said they later regretted something they did when drinking.

“As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning,” said Lake. “Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person’s life can help set them on the right track.”

Changing the Culture of Substance Use is a project currently being implemented at 11 public post-secondary institutions throughout British Columbia. Changing the culture of alcohol and substance use is a long-term process that requires engagement from several levels of society, including communities, organizations, campus administration and individuals.

“Post-secondary students need to make informed choices on the use of alcohol,” said Advanced Education Minister Andrew Wilkinson. “Facilitating a conversation on the use of alcohol is a good way to ensure that students have the full facts.”

Project researchers are working with public post-secondary institutions to create a wider range of resources and strategies, which will engage key groups such as student leaders, students in residence and those in their first year.

“The Centre for Addictions Research of BC at the University of Victoria is pleased to continue its partnership with the Ministry of Health to ensure available evidence is utilized in real-world applications that improve the health of British Columbians,” said Dan Reist, an assistant director at the centre. “In particular, the investment in changing the culture of substance use on post-secondary campuses currently supports locally-developed, centrally-supported projects at 11 institutions and active planning at several others.”

Examples of existing resources include the Drink with Class campaign at Thompson Rivers University which targets students during their first six weeks in residence with multiple programs, policies and strategies to encourage responsible drinking. As well, Selkirk College has a Dinner Baskets program, designed to offer students the opportunity to prepare and enjoy a meal together on a regular basis, and to talk about substance use on campus and how the culture can be changed.

Campus-community partnerships are also being developed to help promote healthier relationships with alcohol among students. Recognizing that campuses exist within the context of a larger community, the partnerships will work with partners such as bars, pubs and transportation systems.

“The Canadian Mental Health Association BC Division appreciates the continued investments in student mental health and well-being by the Ministry of Health,” said Bev Gutray, CEO at CMHA BC. “The Changing the Culture of Substance Use project is an integral part of our work promoting student mental health across British Columbia, through Healthy Minds, Healthy Campuses. With continued government investment, and in partnership with CARBC, we have built a strong and active network of BC campuses focused on ensuring the conditions are in place to increase participation in, and completion of, post-secondary education for all students.”

This investment aligns with the provincial government's 10-year mental-health and substance use plan, Healthy Minds, Healthy People, which focuses on prevention, early intervention, treatment and sustainability of mental health and substance use supports. The announcement meets a commitment within the plan to provide more substance use initiatives across the province.

The Province also offers Alcohol Sense, a comprehensive suite of online resources aimed at providing parents with tools to guide and educate their children to make healthy decisions about alcohol through critical thinking and conversation.

Scheffel, Emile HLTH:EX

From: Thornthwaite, Jane <J.Thornthwaite@leg.bc.ca>
Sent: Tuesday, January 12, 2016 10:34 AM
To: Scheffel, Emile HLTH:EX; Lake, Terry HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Thanks Emile, the reason why I mention HeadSpace is because it is a well known NATIONAL program in Australia, something that I think we should be working towards here in Canada. Our recommendations from the Select Standing Committee on Children and Youth will be focusing on a coordinated provincial approach but in reality it is the Feds who need to step up to the plate with us.

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January 12, 2016 10:24 AM
To: Thornthwaite, Jane <J.Thornthwaite@leg.bc.ca>; Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca>
Cc: Dhanowa, Damon HLTH:EX <Damon.Dhanowa@gov.bc.ca>
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hi Jane,

Thought I would give you a quick response as Minister Lake is tied up at an event this morning.

The federal/provincial/territorial component of the meeting will include a pretty heavy focus on the most pressing challenges facing health care systems, as well as on community care – two areas in which we expect mental health will be one of the top issues.

As you know, mental health and particularly CYMH are areas of high priority for us. Looking forward to sharing more info on these conversations following next week's meetings.

Best,

E

From: Thornthwaite, Jane [mailto:J.Thornthwaite@leg.bc.ca]
Sent: Tuesday, January 12, 2016 10:16 AM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: FW: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hello Minister. Happy New year!

Just wondering if there is an agenda of this meeting and if Child and Youth Mental Health (or Mental Health in general) is on it. I know that there is a generic high level reference to mental health services in the Federal Health Minister's mandate letter, but I'm wondering if a national program (or provincial transfer funding for mental health initiatives) like Australia's HeadSpace model is being talked about plus a plan for First Nations youth either on or off reserve.

In either case, I'm interested to see how far up this issue is on federal minds.

Thank you so much

Jane

Jan. 12, 2016

MEDIA ADVISORY - Federal, provincial and territorial Health Ministers

VANCOUVER - The Honourable Jane Philpott, Canada's Minister of Health, and the Honourable Terry Lake, British Columbia's Minister of Health, will co-chair a meeting of federal, provincial and territorial Health Ministers in Vancouver, B.C., January 20 and 21.

Please note all details are subject to change. All times are local Pacific time. Media teleconference details to be provided at a later date.

DATES:

On January 20, Minister Lake will host provincial and territorial Health Ministers, while both Ministers Philpott and Lake will co-chair the meeting on January 21.

TIMES:

Wednesday, January 20, 2016 - Provincial-territorial Health Ministers' meeting

7:30 a.m. - Media registration opens

8:30 a.m. - Photo opportunity with Ministers prior to start of meeting

3:15 p.m. - News conference with provincial and territorial Health Ministers

Thursday, January 21, 2016 - Federal-provincial-territorial Health Ministers' meeting

7:00 a.m. - Media registration opens

8:00 a.m. - Photo opportunity with Ministers prior to start of meeting

2:20 p.m. - News conference with federal, provincial and territorial Health Ministers

LOCATION:

All media events will be held at the Fairmont Hotel Vancouver
900 West Georgia Street
Vancouver, B.C.

Media who wish to attend must register upon arrival and obtain accreditation by presenting press identification at the Saturna Island Room.

CONTACTS:

Media Relations
B.C. Ministry of Health
250 952-1887

Media Relations
Health Canada
613 957-2983

Scheffel, Emile HLTH:EX

From: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Sent: Tuesday, January 12, 2016 10:24 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Follow Up Flag: Follow up
Flag Status: Flagged

Good morning Emile,

MLA Simons will be in Victoria on January 21st. Can you please advise if that date would work for your staff?

Thanks,

Elizabeth

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January 12, 2016 10:09 AM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Subject: RE: Questions from MLA Simons

Good morning Elizabeth,

We will be happy to make our director of maternal health available – could you let me know a few dates and times in the next couple of weeks that would work on your end?

Thanks E

From: Parkinson, Elizabeth [mailto:Elizabeth.Parkinson@leg.bc.ca]
Sent: Monday, January 4, 2016 3:01 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Thank you Emile.

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January 4, 2016 3:00 PM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Cc: Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Subject: RE: Questions from MLA Simons

Thanks Elizabeth. I have asked staff to indicate availability.

From: Parkinson, Elizabeth [mailto:Elizabeth.Parkinson@leg.bc.ca]
Sent: Monday, January 4, 2016 2:59 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Thanks Emile. I believe this is about financial coverage for hearing aids for children. Apparently the Lions Club used to help families, but is now unable to provide families that financial assistance.

Hi Elizabeth,

We'd be happy to set this up.

Is there any more specific info I can pass along to staff to assist them in preparing?

Thanks E

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]

Sent: Monday, January 4, 2016 2:54 PM

To: Scheffel, Emile HLTH:EX

Subject: Questions from MLA Simons

Good afternoon Emile,

MLA Nicholas Simons has asked me to set-up a call or meeting with MoH staff regarding questions he has about children's hearing aids. Can you please confirm a time this would be possible?

Best regards,

Elizabeth Parkinson | Legislative Assistant |

New Democrat Official Opposition Caucus

T: 250.387-1665 | F: 250.387.4680

elizabeth.parkinson@leg.bc.ca | www.bcndpcaucus.ca

Scheffel, Emile HLTH:EX

From: James, Ben <Ben.James@leg.bc.ca>
Sent: Tuesday, January 12, 2016 10:18 AM
Subject: News You Can Use: Supporting Miracles with Personalized Onco-Genomics

News You Can Use: Supporting Miracles with Personalized Onco-Genomics

Premier Christy Clark and Health Minister Terry Lake have announced government funding of \$3 million to the BC Cancer Foundation in support of the Personalized Onco-Genomics program and other high-priority cancer projects.

Key Messages:

- This funding announcement, made possible by a strong, growing, and diverse economy, will help the BC Cancer Agency continue to find unique cures for the hardest to beat cancers.
- The Personalized Onco-Genomics (POG) program represents the future of cancer care: personalized treatments based on each patient's unique DNA, giving hope to those with the most aggressive or recurring forms of cancer.
- By understanding the genetic makeup of a patient's tumour, researchers hope to pinpoint potential drug therapies that are the most effective for the individual patient, sparing patients and the health care system from treatments that may provide less benefit.
- The funding announced today will help the POG program expand from its current 350 patients to 2,000 over the next 5 years. So far, the program has treated patients with 50 different types of cancer.
- This investment adds to the \$2 million provided to the BC Cancer Foundation last October to support breast cancer research.
- Thanks to investments like these, British Columbia has some of the lowest cancer incidence rates and the highest overall survival rate in Canada.

Link to News Release: <http://ow.ly/WXOqs>

Suggested Tweets:

- \$3M funding 4 personalized cancer treatment. <http://ow.ly/WXOqs> @christyclarkbc @TerryLakeMLA @BCCancer_Agency @bccancer
- Supporting personalized cancer treatments. <http://ow.ly/WXOqs> @christyclarkbc @TerryLakeMLA @BCCancer_Agency @bccancer
- A boost for those with the most aggressive/recurring forms of cancer. <http://ow.ly/WXOqs> @christyclarkbc @TerryLakeMLA @bccancer

*Ben James
Director of Communications
BC Liberal Government Caucus
250-356-9131 (office)
250-208-7052 (mobile)*

Progress Report to Treasury Board

Minister: Honourable Terry Lake

Ministry: Health

Date: December 2015

Ministry Document #: H15-20

Title: Doubling of Hospice Spaces Progress Report

s.12

Page 0125 to/à Page 0127

Withheld pursuant to/removed as

s.12

Scheffel, Emile HLTH:EX

From: James, Ben <Ben.James@leg.bc.ca>
Sent: Tuesday, January 12, 2016 11:33 AM
Subject: Link to release and suggested tweets

Release is posted:

BC #NDP refuses to take a stand on the new St. Paul's Hospital campus of care – Another example of them putting politics ahead of principles: <http://ow.ly/WXZaT>

We've been consistent – We support a new, modernized St Paul's Hospital campus of care. Where do the BC #NDP stand? <http://ow.ly/WXZaT>

Do they or don't they – It's time BC NDP stopped flip-flopping on the new, cutting edge St Paul's Hospital: <http://ow.ly/WXZaT>

New St Paul's Hospital – Another case of the BC #NDP sticking their finger in the air to decide policy rather than sticking with principles: <http://ow.ly/WXZaT>

Add St Paul's Hospital to the list of projects John Horgan & the #NDP refuses to clearly and consistently support or oppose: <http://ow.ly/WXZaT>

*Ben James
Director of Communications
BC Liberal Government Caucus
250-356-9131 (office)
250-208-7052 (mobile)*

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 11:22 AM
To: Scheffel, Emile HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: Re: e-Prescribing update

Ok

Terry Lake DVM
Minister of Health

On Jan 12, 2016, at 11:09 AM, "Scheffel, Emile HLTH:EX" <Emile.Scheffel@gov.bc.ca> wrote:

Minister,

If you're amenable, staff can give you a quick update on e-Prescribing right after your 2:15 briefing on BC Clinical & Support Services – as Sabine will be with you and Deb will be on the phone.

If time runs out, or if you want more detail, we can schedule some time separately.

Thanks E

Scheffel, Emile HLTH:EX

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 11:17 AM
To: Scheffel, Emile HLTH:EX; Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX
Subject: Kanaka Creek Lodge residents needing assistance

FYI, can we get some info on this please. thanks :D

From: Dalton.MLA, Marc [mailto:Marc.Dalton.MLA@leg.bc.ca]
Sent: Tuesday, January 12, 2016 11:15 AM
To: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: Kanaka Creek Lodge residents needing assistance

Hi, Damon and Derek

Cheryl Ennis, the Executive Assistant for Mayor Nicole Read in Maple Ridge called just now. On Saturday evening the Kanaka Creek Lodge was destroyed by fire. The 10 residents, all elderly men requiring daily support have been staying at the Quality Inn where their care aids and meals and medication are all be arranged by the Lodges staff.

However, tomorrow morning, the 72 hours of emergency financial support for the men expires and they will all be out on the street. My first thought when Cheryl said this was that it sure won't look good in the media tomorrow.

Mrs. Ennis, from City Hall, says that none of the men have family who can be of temporary support. She wanted to speak to Marc, but since he is away, I said I would contact you to see how we can go about providing these gentlemen extended support until they can be found new living arrangements.

If this information is not going to be enough for you to do something, could you let me know what I can do to help you help them.

I look forward to your response.

Kind regards,

Laurie Geschke
Constituency Assistant
for

Marc Dalton, MLA, Maple Ridge – Mission

(604) 476-4530 or 1.877.899.3215

Please note that I am in the office on Tuesdays, Wednesdays and Fridays.

Scheffel, Emile HLTH:EX

From: James, Ben <Ben.James@leg.bc.ca>
Sent: Tuesday, January 12, 2016 11:17 AM
Subject: NDP NEED TO MAKE UP THEIR MINDS ON NEW ST. PAUL'S HOSPITAL

BC Government Caucus
News Release

January 12, 2016

NDP NEED TO MAKE UP THEIR MINDS ON NEW ST. PAUL'S HOSPITAL

VICTORIA – Health Minister Terry Lake says it's past time for the NDP to make up their minds on a new St. Paul's Hospital and health care campus that will benefit Lower Mainland residents and all British Columbians.

"When we made the announcement, the NDP wasted no time opposing the plan," says Lake. "I directly asked opposition MLAs whether they supported this investment of more than \$1 billion in a new, cutting edge health care campus – and they refused to take a stand."

But now, reports in Chinese-language media suggest an NDP candidate has come out in support of St. Paul's – suggesting the NDP puts politics ahead of policy principles.

"We've been consistent on where we stand and how we're going to achieve our goals to deliver even better health care for British Columbians," says Lake. "Spencer Chandra Herbert was the loudest voice when it came to opposing the new St. Paul's, and but now it seems he may have been thrown under the by-election bus. It just shows a consistent pattern of the NDP not sticking with principles, but sticking their finger up to see which way the wind is blowing."

By re-developing St. Paul's Hospital at the 18.5 acre Station Street site instead of the current Burrard Street location will allow the following programs and services to be developed that would not be possible on the existing site:

- 24/7 primary care;
- Chronic Disease Management Services;
- Mental Health and Addictions beds and services and programs;
- Non-acute medical services;
- Laboratory;
- Low-risk birthing centre;
- End of life care;
- Residential care beds;
- Social Housing; and
- Wellness and Community Care programs.

The new hospital will continue as one of British Columbia's two most specialized hospitals for adults. It will also be at the centre of a network of new and existing dedicated primary care services in the region, including services to support those living in Vancouver's West End. In addition, as part of the Station Street development, Providence Health Care will look at building a number of social housing units to provide affordable housing options for Vancouver residents.

-30-

*Ben James
Director of Communications
BC Liberal Government Caucus
250-356-9131 (office)
250-208-7052 (mobile)*

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 11:10 AM
To: Dhanowa, Damon HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: Re: Quote Approval: Equipemnt for West Chilcotin

Fine.

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 10:34 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: Quote Approval: Equipemnt for West Chilcotin

Good morning Minister – 2/2 with regard for quotes today. This NR is set to release on Thursday morning.
Thanks :D s.17

“Supporting primary care in rural and remote communities is a priority in our work to strengthen the health-care model for all British Columbians,” says Health Minister Terry Lake. “This medical equipment will help staff at the West Chilcotin Health Centre deliver high quality care closer to where their patients live and work.”

Medical equipment funding for clinic in B.C.’s wild, rugged and beautiful West Chilcotin

TATLA LAKE – The West Chilcotin Healthcare Society received \$50,000 from the Province for specialized equipment for their remote medical clinic. The clinic provides primary and interim emergency care to a tight knit community of 500 people.

“Supporting primary care in rural and remote communities is a priority in our work to strengthen the health-care model for all British Columbians,” says Health Minister Terry Lake. “This medical equipment will help staff at the West Chilcotin Health Centre deliver high quality care closer to where their patients live and work.”

This Interior Health clinic serves the regions of Kleena Klene, Puntzi, Chilko, Bluff, Sapeye, Tatla and Tatlayoko lakes. Dr. Robert Coetzee provides medical services at the West Chilcotin Health Centre, which is staffed by Ruth Kuehl-Venn a remote certified nurse and receptionist April Wright. With the nearest hospital three hours away by road in Williams Lake, the staff provide a wide variety of care daily, and emergency medicine as needed while ambulance support is on the way.

“The ranchers, loggers and old homesteader families of the West Chilcotin are an incredibly self-reliant community,” said Donna Barnett, MLA for Cariboo-Chilcotin. “Providing this equipment supports this independence, while ensuring medical staff have the right tools at their fingertips to provide medical care quickly and effectively.”

The government funds supplement the \$40,000 raised in the community over the past several years. Seeing a need to provide updated and specialized medical equipment for the community, residents and local

In an area where house calls are a regular part of family practice, Dr. Smialowski shares that in a community where you know everybody, doctors may attend to patients wherever they are, at all hours, for a wide variety of medical concerns.

“Depending on the severity of the call, we may provide complete medical treatment for our patients on the spot or stabilize them until an ambulance arrives by air or road, which can sometimes take several hours,” said Smialowski. “Having specialized medical equipment, such as a cardiac monitor and defibrillator or an intra-osseous drill can mean better emergency medical treatment and outcomes for patients.”

To improve health care for British Columbians in every region of the province, the Ministry of Health has developed the overarching strategy, Setting Priorities for the B.C. Health System. As part of this, a series of policy papers – with a focus on primary and community care, rural health services and health human resources – were created to help guide the changes needed to build a better health system.

Scheffel, Emile HLTH:EX

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 11:02 AM
To: Scheffel, Emile HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: RE: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

I'll forward to staff.

Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:01 AM
To: Andrachuk, Andrea HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: RE: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

Definitely helpful thanks! Just wondering if we can get an answer to bullet 2:

- Starting # of beds
- How many added to date
- How many planned by end of 2016

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 10:58 AM
To: Scheffel, Emile HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

Hi Emile,

Would the attached progress report on Hospice spaces do for your update request?

Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Docs Processing HLTH:EX
Sent: Monday, January 4, 2016 10:37 AM
To: HLTH Ministers Office
Cc: Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: Progress Report to Treasury Board - H15-20 - Doubling of Hospice Spaces (Cliff 1041217)

Hi All:

Kathy Simonson

Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 11:34 AM
To: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX; Scheffel, Emile HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: POG
Attachments: Pog.mp3; Scrum.mp3

Event went well.

Here is the audio from the media avail and an impromptu interview on Dr. Montaner/Naloxine.

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

Scheffel, Emile HLTH:EX

From: Robin Dhir <rdhir@fasken.com>
Sent: Tuesday, January 12, 2016 11:42 AM
To: Merrifield, Katy PREM:EX; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Shaina,

Do you have any updates for me?

Thx,

Robin

From: Merrifield, Katy HLTH:EX [mailto:Katy.Merrifield@gov.bc.ca]
Sent: January-07-16 3:39 PM
To: Robin Dhir; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Robin,

Same to you! I've included the Minister's AC Shaina who will get back to you on the Minister's availability.

Cheers,

Katy Merrifield
Chief of Staff to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547
Katy.Merrifield@gov.bc.ca

From: Robin Dhir [mailto:rdhir@fasken.com]
Sent: Thursday, January 7, 2016 3:37 PM
To: Merrifield, Katy HLTH:EX
Subject: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Katy,

Happy New Year!

I wanted to reach out and share the below invite for Minister Lake.

I would like to invite him to be my (Faskens) guest at this luncheon. Perhaps, he has already been invited by the organizers, but if not, it would be my pleasure to host him.

We are the Presenting Sponsor and as such have the prime table in the room in front of the stage. We would arrange for him to speak as well.

Please let me know at your earliest convenience if this will work with his schedule.

Regards



illuminate.



YOU ARE INVITED TO THE ILLUMINATIONS FUNDRAISING
LUNCHEON IN SUPPORT OF BC WOMEN'S HOSPITAL.

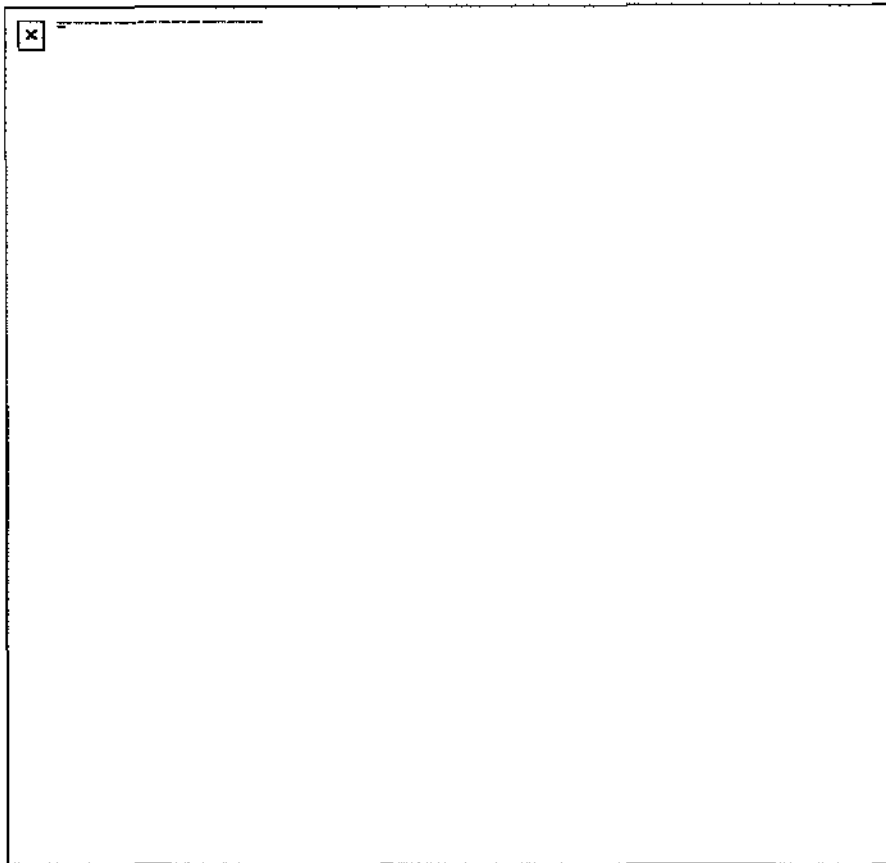


Please join us and our special guest speaker Deepa Mehta
for an engaging + inspiring afternoon.

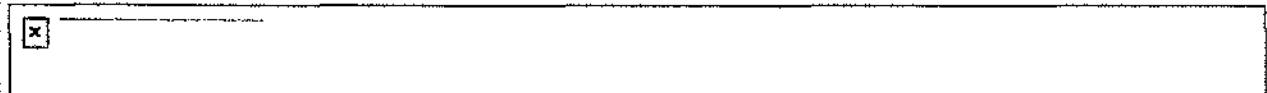


FOUR SEASONS HOTEL
791 WEST GEORGIA, VANCOUVER

*Ballroom doors open at 11:30 am. Program starts at 12:00 pm.



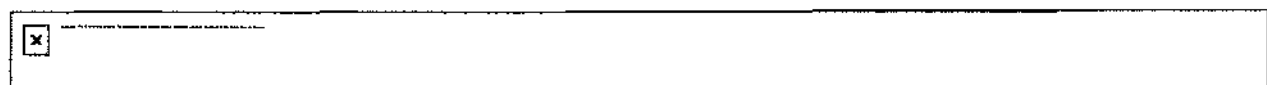
KEYNOTE SPEAKER: DEEPA MEHTA
OSCAR-NOMINATED FILMMAKER



Deepa Mehta is an Oscar-nominated (*Water*), transnational filmmaker whose work is celebrated on an international scale. Her award-winning films have played every major film festival, receiving numerous awards and many remain audience favourites.

Deepa's work challenges traditions and stereotypes and is always daring, fearless and provocative. In 2013, Deepa was appointed an officer of The Order of Canada for her groundbreaking contribution to film.

We are honoured that she will be joining us.



Hospital specifically related to women's healthcare. The funds from this luncheon will directly improve hospital programs, research, equipment and facilities to benefit the health and well-being of women locally and across our entire province.

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BC WOMEN'S HOSPITAL + HEALTH CENTRE FOUNDATION
4500 OAK STREET, ROOM D310, VANCOUVER, BC V6H 3N1

special events, and other opportunities to give.

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Scheffel, Emile HLTH:EX

From: Paton, Arlene HLTH:EX
Sent: Tuesday, January 12, 2016 12:25 PM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Sidhu, Manjit HLTH:EX
Subject: FW: in follow up regarding TasP for HIV and viral hep project

Hi Minister – Julio Montaner has contacted me to ask for a funding letter so that he can get started on the hep C initiative, as he states he has received a note from you saying it's approved (please see his note below). The decision note you approved says you'll consider this \$5m as part of the year end funding discussions.

Please let me and Manjit know if you want us to proceed directly or wait to see the list of potential year end funding options.

Thanks – and Happy New Year!

Regards,

Arlene Paton
Assistant Deputy Minister
Population and Public Health
Ministry of Health
PO Box 9646 Stn Prov Govt
Victoria BC V8W 9P1
Tel: 250-952-1731

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From: Dr. Julio Montaner [<mailto:drjm@cfeenet.ubc.ca>]
Sent: Thursday, January 7, 2016 3:01 PM
To: Paton, Arlene HLTH:EX
Cc: Kendall, Perry HLTH:EX; McGowan, Gina HLTH:EX; O'Briain, Warren W HLTH:EX; XT:HLTH Day, Irene
Subject: in follow up regarding TasP for HIV and viral hep project

Dear Arlene, let me first thank you and Perry for hosting us earlier this week. We were very pleased to meet your colleagues and to share with them our work to date and some of the opportunities in front of us.

I also appreciate the opportunity to touch base briefly with you and separately with Perry regarding the recent decision by Minister Lake to go forward with our HCV proposal. We are very keen to move this forward asap.

As we discussed, and as I indicated to Gina earlier today, we are ready to go, however, we need to formalize a couple of issues. First, while I have a written statement from the Minister regarding the approval of the project, I think we need a formal letter to that effect. Next, we need to ensure access to the data. Based on our experience with the last HCV project, we need to ensure that my team has full and unrestricted access to the data, obviously as guided by the protocol. We need this before we can commit to the work, and develop the formal announcement and the timeline.

In this context, we discuss having a meeting next week. I think this would be a very important next step. I look forward to making this a priority.

Julio S. G. Montaner, OC, OBC, MD, DSc (hon), FRCPC, FCCP, FACP, FRSC
Professor and Head, UBC-Division of AIDS
UBC and St. Paul's Hospital Foundation Chair in AIDS Research
Faculty of Medicine, University of British Columbia;
Director, BC Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Providence Healthcare;
UNAIDS Special Advisor on HIV Therapeutics;
Past-President, International AIDS Society.

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Scheffel, Emile HLTH:EX

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 12:10 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Ok will do

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 12:10 PM
To: Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Go for it, thanks!

Let's just emphasize MTL has a prior commitment.

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 12:09 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

I think it is certainly interesting. Perhaps I should call this person and ensure they are amenable to hosting a member before making the offer?

It's Sam's riding and normally he doesn't attend these things unless we insist (I will say this is different to what we usually offer).

Looks like a cool little luncheon though. Let me know if you'd like me to reach out. I guess another member option would be Dr. Stilwell, might be more appropriate considering it is in support of the BC Women's Hospital.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:59 AM
To: Jukes, Shaina HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Thx – Damon what do you think

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 11:58 AM
To: Scheffel, Emile HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: FW: Illuminations Luncheon - Jan 26, 2016 - INVITATION

MTL has CCST this day so I was going to send regrets, do we want to offer an MLA or anything?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2*

Hi Shaina,

Do you have any updates for me?

Thx,

Robin

From: Merrifield, Katy HLTH:EX [<mailto:Katy.Merrifield@gov.bc.ca>]
Sent: January-07-16 3:39 PM
To: Robin Dhir; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Robin,

Same to you! I've included the Minister's AC Shaina who will get back to you on the Minister's availability.

Cheers,

Katy Merrifield
Chief of Staff to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547
Katy.Merrifield@gov.bc.ca

From: Robin Dhir [<mailto:rdhir@fasken.com>]
Sent: Thursday, January 7, 2016 3:37 PM
To: Merrifield, Katy HLTH:EX
Subject: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Katy,

Happy New Year!

I wanted to reach out and share the below invite for Minister Lake.

I would like to invite him to be my (Faskens) guest at this luncheon. Perhaps, he has already been invited by the organizers, but if not, it would be my pleasure to host him.

We are the Presenting Sponsor and as such have the prime table in the room in front of the stage. We would arrange for him to speak as well.

Please let me know at your earliest convenience if this will work with his schedule.

Regards,

Robin Dhir | Strategic Advisor

T. +1 604 631 4953 | C. +1 604 786 0429 | F. +1 604 631 3232
rdhir@fasken.com | www.fasken.com

Fasken Martineau DuMoulin LLP
2900 - 550 Burrard Street, Vancouver, British Columbia, V6C 0A3

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VANCOUVER CALGARY TORONTO OTTAWA MONTREAL QUEBEC
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LUNCHEON IN SUPPORT OF BC WOMEN'S HOSPITAL.

Please join us and our special guest speaker Deepa Mehta
for an engaging + inspiring afternoon.

PRESENTED BY
FASKEN MARTINEAU

ILLUMINATIONS

FUNDRAISING LUNCHEON



TUESDAY, JANUARY 26, 2016 – 12:00 PM – 2:00 PM*
FOUR SEASONS HOTEL
791 WEST GEORGIA, VANCOUVER



KEYNOTE SPEAKER: DEEPA MEHTA
OSCAR-NOMINATED FILMMAKER

Deepa Mehta is an Oscar-nominated (*Water*), transnational filmmaker whose work is celebrated on an international scale. Her award-winning films have played every major film festival, receiving numerous awards and many remain audience favourites.

Deepa's work challenges traditions and stereotypes and is always daring, fearless and provocative. In 2013, Deepa was appointed an officer of The Order of Canada for her groundbreaking contribution to film.

We are honoured that she will be joining us.

Illuminations is an annual fundraising event organized by BC Women's Hospital + Health Centre Foundation. This high-profile event consistently sells out and attracts over 400 representatives from business, industry and private sectors of Vancouver.



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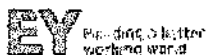


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BC WOMEN'S HOSPITAL + HEALTH CENTRE FOUNDATION
4500 OAK STREET, ROOM D310, VANCOUVER, BC V6H 3N1

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Scheffel, Emile HLTH:EX

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 12:09 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

I think it is certainly interesting. Perhaps I should call this person and ensure they are amenable to hosting a member before making the offer?

It's Sam's riding and normally he doesn't attend these things unless we insist (I will say this is different to what we usually offer).

Looks like a cool little luncheon though. Let me know if you'd like me to reach out. I guess another member option would be Dr. Stilwell, might be more appropriate considering it is in support of the BC Women's Hospital.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:59 AM
To: Jukes, Shaina HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Thx – Damon what do you think

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 11:58 AM
To: Scheffel, Emile HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: FW: Illuminations Luncheon - Jan 26, 2016 - INVITATION

MTL has CCST this day so I was going to send regrets, do we want to offer an MLA or anything?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Robin Dhir [<mailto:rdhir@fasken.com>]
Sent: Tuesday, January 12, 2016 11:42 AM
To: Merrifield, Katy PREM:EX; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Shaina,

Do you have any updates for me?

Thx,

Robin

Same to you! I've included the Minister's AC Shaina who will get back to you on the Minister's availability.

Cheers,

Katy Merrifield

Chief of Staff to the Honourable Terry Lake

Minister of Health

Office: (250) 953-3547

Katy.Merrifield@gov.bc.ca

From: Robin Dhir [<mailto:rdhir@fasken.com>]

Sent: Thursday, January 7, 2016 3:37 PM

To: Merrifield, Katy HLTH:EX

Subject: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Katy,

Happy New Year!

I wanted to reach out and share the below invite for Minister Lake.

I would like to invite him to be my (Faskens) guest at this luncheon. Perhaps, he has already been invited by the organizers, but if not, it would be my pleasure to host him.

We are the Presenting Sponsor and as such have the prime table in the room in front of the stage. We would arrange for him to speak as well.

Please let me know at your earliest convenience if this will work with his schedule.

Regards,

Robin Dhir | Strategic Advisor

T. +1 604 631 4953 | C. +1 604 786 0429 | F. +1 604 631 3232

rdhir@fasken.com | www.fasken.com

Fasken Martineau DuMoulin LLP

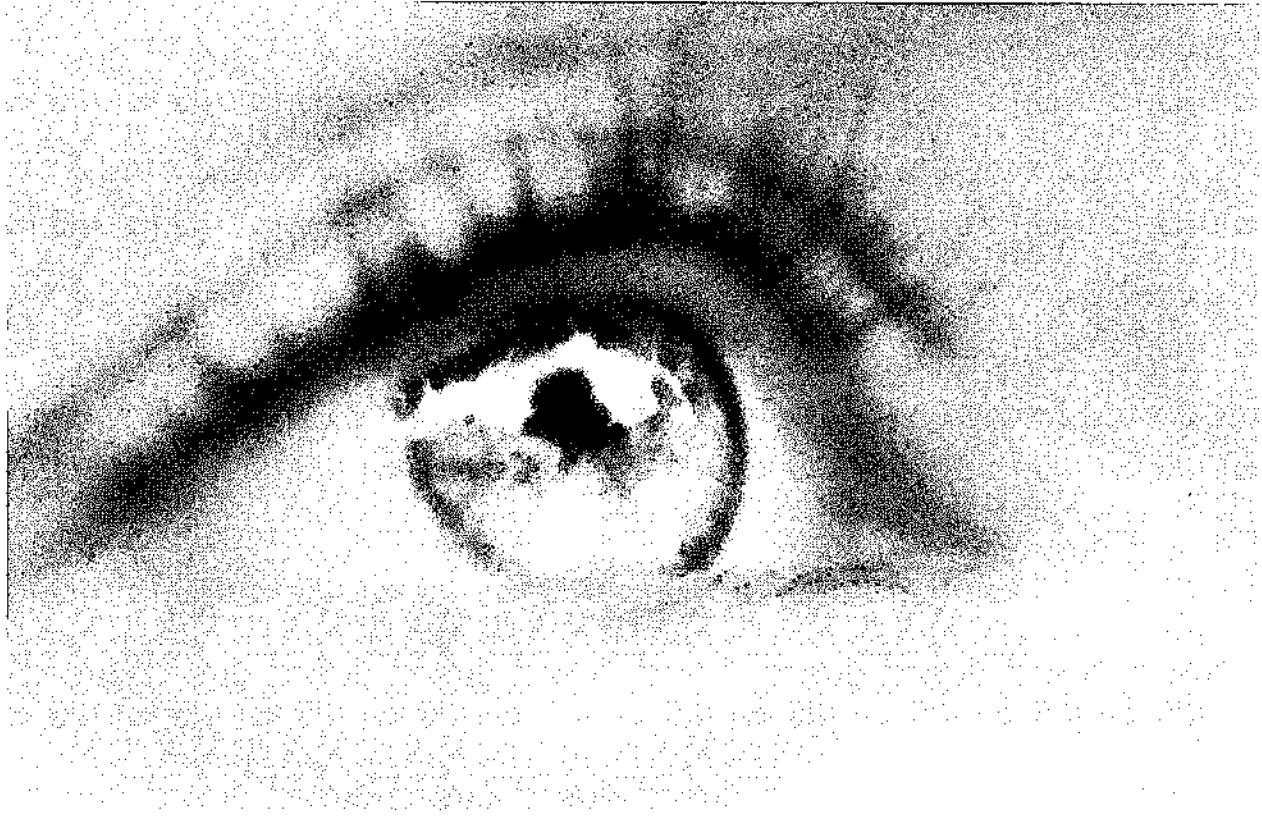
2900 - 550 Burrard Street, Vancouver, British Columbia, V6C 0A3

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YOU ARE INVITED TO THE ILLUMINATIONS FUNDRAISING
LUNCHEON IN SUPPORT OF BC WOMEN'S HOSPITAL.

Please join us and our special guest speaker Deepa Mehta
for an engaging + inspiring afternoon.

PRESENTED BY
FASKEN MARTINEAU

ILLUMINATIONS

FUNDRAISING LUNCHEON



TUESDAY, JANUARY 26, 2016 – 12:00 PM – 2:00 PM*
FOUR SEASONS HOTEL
791 WEST GEORGIA, VANCOUVER

*Ballroom doors open at 11:30 am. Program starts at 12:00 pm.

Scheffel, Emile HLTH:EX

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 12:10 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Ok will do

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 12:10 PM
To: Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Go for it, thanks!

Let's just emphasize MTL has a prior commitment.

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 12:09 PM
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Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

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Shaina Jukes

Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2

Hi Shaina,

Do you have any updates for me?

Thx,

Robin

From: Merrifield, Katy HLTH:EX [<mailto:Katy.Merrifield@gov.bc.ca>]
Sent: January-07-16 3:39 PM
To: Robin Dhir; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Robin,

Same to you! I've included the Minister's AC Shaina who will get back to you on the Minister's availability.

Cheers,

Katy Merrifield
Chief of Staff to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547
Katy.Merrifield@gov.bc.ca

From: Robin Dhir [<mailto:rdhir@fasken.com>]
Sent: Thursday, January 7, 2016 3:37 PM
To: Merrifield, Katy HLTH:EX
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Regards,

Robin Dhir | Strategic Advisor

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rdhir@fasken.com | www.fasken.com

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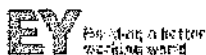


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4500 OAK STREET, ROOM D310, VANCOUVER, BC V6H 3N1

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Scheffel, Emile HLTH:EX

From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 11:59 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: FN videos for FPT Reception

Great – that’s what I was thinking as well. We’ll run the first by him on Thurs, and not worry about the second.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:58 AM
To: Poilievre, Tricia HLTH:EX
Subject: RE: FN videos for FPT Reception

Thanks! First one for sure, but let’s please run by MTL as well. I don’t think the 2nd would work very well in this context.

From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 11:55 AM
To: Scheffel, Emile HLTH:EX
Cc: Poilievre, Tricia HLTH:EX
Subject: FN videos for FPT Reception

Hi Emile,

Not sure if you’ve seen these, as it’s been a while since we last discussed them with Katy. In our first HMM briefing with MTL back in the fall, we talked about including two brief video presentations on BC’s work with First Nations, for the FPT reception on Jan 20.

The two options staff here have recommended are:

BC FNHA Premier’s awards video (2014):
<https://www.youtube.com/watch?v=1fhqkgMwIkQ>

BC FN Leaders/Cabinet Gathering (2015):
<https://www.youtube.com/watch?v=5hlxtKBRvEA&feature=youtu.be>

We have time on the reception agenda to show both or just one of the above videos, or can easily remove them if MTL decides against it. I’m wondering if you have any feedback or preferences between them? We can show them to MTL on Thursday as well.

Thanks!

Tricia Poilievre
A/Director | Intergovernmental Relations | Ministry of Health, BC
Office: 250 952-1304 | Cell: 250 415-2639 | tricia.poilievre@gov.bc.ca

Scheffel, Emile HLTH:EX

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 1:56 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: PCC mtg tomorrow

Hi Emile,

There is nothing in the DM's calendar and we've not been looped in. I will leave to Shaina to respond if there was any verbal indication.

Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 1:53 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: PCC mtg tomorrow

I'm sorry to ask so late -- do we have any indication of agenda for PCC/MTL meeting tomorrow?

Thanks E

Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 12:55 PM
To: Scheffel, Emile HLTH:EX; Morris, Kirsty L LASS:EX
Cc: Jukes, Shaina HLTH:EX
Subject: Re: Mtg with MTL & Phoenix Centre

I will request materials from staff.

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 12:53 PM
To: Morris, Kirsty L LASS:EX; Robertson, Derek HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: Mtg with MTL & Phoenix Centre

Thanks! Derek and Shaina, can I leave staff and materials to you?

Thanks E

From: Morris, Kirsty L [mailto:Kirsty.Morris@leg.bc.ca]
Sent: Tuesday, January 12, 2016 12:52 PM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: Mtg with MTL & Phoenix Centre

Meeting has been arranged for **Thursday February 4th at 10am** - I have put it in the calendar

Over to you.....

Thank you!

Kirsty

Kirsty L Morris | Constituency Assistant

Terry Lake, MLA Kamloops - North Thompson
Minister of Health

Email: kirsty.morris@leg.bc.ca
Phone #: [250-554-5413](tel:250-554-5413) Fax #: [250-554-5417](tel:250-554-5417)
Toll Free #: [1-888-299-0805](tel:1-888-299-0805)
Website: www.terrylakemla.bc.ca

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 11, 2016 1:51 PM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>; Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Cc: Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca>
Subject: RE: Mtg with MTL & Phoenix Centre

Great thx!

From: Morris, Kirsty L [<mailto:Kirsty.Morris@leg.bc.ca>]
Sent: Monday, January 11, 2016 12:29 PM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: Mtg with MTL & Phoenix Centre

Of course...I will let you know once arranged....

Kirsty L Morris | Constituency Assistant

*Terry Lake, MLA Kamloops - North Thompson
Minister of Health*

Email: kirsty.morris@leg.bc.ca
Phone #: [250-554-5413](tel:250-554-5413) Fax #: [250-554-5417](tel:250-554-5417)
Toll Free #: [1-888-299-0805](tel:1-888-299-0805)
Website: www.terrylakemla.bc.ca



Be Green! Read from the screen

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 11, 2016 11:12 AM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>; Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Cc: Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca>
Subject: RE: Mtg with MTL & Phoenix Centre

Could we leave scheduling to you and provide materials/staff from our end?

From: Morris, Kirsty L [<mailto:Kirsty.Morris@leg.bc.ca>]
Sent: Monday, January 11, 2016 11:11 AM
To: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: Mtg with MTL & Phoenix Centre

Good Morning All!

The following meeting request has been received in the CO from the ED of the Phoenix Centre which is located here in Kamloops.

MTL has reviewed the request this morning and agreed to this meeting.

As this is Health, let me know if you wish to take over arrangements for this meeting.

MTL has requested BN and staff for this meeting and he also wants Interior Health informing that he will be meeting with them in advance.

Kirsty L Morris | Constituency Assistant

Terry Lake, MLA Kamloops - North Thompson
Minister of Health

Email: kirsty.morris@leg.bc.ca

Phone #: 250-554-5413 Fax #: 250-554-5417

Toll Free #: 1-888-299-0805

Website: www.terrylakemla.bc.ca



Be Green! Read from the screen

From: Sian Lewis [<mailto:sian.lewis@phoenixcentre.org>]

Sent: January 8, 2016 2:57 PM

To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>

Cc: Shelly Bonnah <SBonnah@interiorcommunityservices.bc.ca>

Subject: Requested meeting with Terry Lake

Hello Kirsty,

Thank you for your time this afternoon. Below is the information requested.

I request a meeting with Hon. Dr. Terry Lake to discuss the *Supportive Transitional Living in Recovery* (STLR) pilot project. This program is specific to those who have recently completed the withdrawal management (detox) component of addiction treatment and require a supportive *living-in-recovery* community to maintain abstinence and engage fully in their ongoing treatment plan.

<http://www.phoenixcentre.org/supportive-transitional-living>

This project was initiated in the spring of 2013 with funding from United Way, Royal Inland Hospital Foundation and Stollery Foundation. This past fiscal, the program also received one-time funding from the Homelessness Partnering Strategy via the City of Kamloops. We are grateful to our funders for their two-year commitment and are now looking for permanent funding to ensure this program is sustained well into the future. We have approached our local health authority to request support, but currently there is no ability for them to commit financially to this program.

I understand the development of 'an additional 500 addiction spaces' (Ministry of Health, 2014/15 – 2016/17, Service Plan) falls within your portfolio; and I am hopeful this initiative aligns well with my objective to secure permanent funding for this critical health-focused transitional housing program. Phoenix Centre has been part of the regional review of the substance use continuum of care. We know sanctioned community-based supportive-living-in-recovery programs are cost efficient and effective.

- Approximate annual program cost is \$100,000.00 to support 11 clients in early recovery
- Program has been at full capacity since opening November 2013
- Clients are in a tenancy agreement; therefore pay their own living expenses (rent, food, etc.)
- We have tracked as much as a 83% decrease in these clients accessing emergency department, RCMP and/or ambulance services (specific to their substance use)
- STLR is part of the youth housing inventory managed by the A Way Home Committee and supported by the Wrap Force
- Allowable length of stay is not predetermined, but client stays range from 3 months to 12 months, with clients 'graduating' to permanent independent housing upon discharge
- Client successes include reaching sobriety milestones, securing employment, volunteering in the community, and/or entering into an educational program
- Our pre and post client surveys consistently reflect improvements in multiple life domains (physical & mental)



Sian Lewis, MSW, RSW

Executive Director

Phoenix Centre™

Telephone: 250-374-4634

Fax: 250-374-4621

Sian.Lewis@phoenixcentre.org

Scheffel, Emile HLTH:EX

From: Thornthwaite, Jane <J.Thornthwaite@leg.bc.ca>
Sent: Tuesday, January 12, 2016 12:54 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Follow Up Flag: Follow up
Flag Status: Completed

Hi Emile, is MTL going to give us an update on this meeting?

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January 12, 2016 10:24 AM
To: Thornthwaite, Jane <J.Thornthwaite@leg.bc.ca>; Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca>
Cc: Dhanowa, Damon HLTH:EX <Damon.Dhanowa@gov.bc.ca>
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hi Jane,

Thought I would give you a quick response as Minister Lake is tied up at an event this morning.

The federal/provincial/territorial component of the meeting will include a pretty heavy focus on the most pressing challenges facing health care systems, as well as on community care – two areas in which we expect mental health will be one of the top issues.

As you know, mental health and particularly CYMH are areas of high priority for us. Looking forward to sharing more info on these conversations following next week's meetings.

Best,

E

From: Thornthwaite, Jane [mailto:J.Thornthwaite@leg.bc.ca]
Sent: Tuesday, January 12, 2016 10:16 AM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: FW: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hello Minister. Happy New year!

Just wondering if there is an agenda of this meeting and if Child and Youth Mental Health (or Mental Health in general) is on it. I know that there is a generic high level reference to mental health services in the Federal Health Minister's mandate letter, but I'm wondering if a national program (or provincial transfer funding for mental health initiatives) like Australia's HeadSpace model is being talked about plus a plan for First Nations youth either on or off reserve.

In either case, I'm interested to see how far up this issue is on federal minds.

Thank you so much

Jane

MEDIA ADVISORY - Federal, provincial and territorial Health Ministers

VANCOUVER - The Honourable Jane Philpott, Canada's Minister of Health, and the Honourable Terry Lake, British Columbia's Minister of Health, will co-chair a meeting of federal, provincial and territorial Health Ministers in Vancouver, B.C., January 20 and 21.

Please note all details are subject to change. All times are local Pacific time. Media teleconference details to be provided at a later date.

DATES:

On January 20, Minister Lake will host provincial and territorial Health Ministers, while both Ministers Philpott and Lake will co-chair the meeting on January 21.

TIMES:

Wednesday, January 20, 2016 - Provincial-territorial Health Ministers' meeting

7:30 a.m. - Media registration opens

8:30 a.m. - Photo opportunity with Ministers prior to start of meeting

3:15 p.m. - News conference with provincial and territorial Health Ministers

Thursday, January 21, 2016 - Federal-provincial-territorial Health Ministers' meeting

7:00 a.m. - Media registration opens

8:00 a.m. - Photo opportunity with Ministers prior to start of meeting

2:20 p.m. - News conference with federal, provincial and territorial Health Ministers

LOCATION:

All media events will be held at the Fairmont Hotel Vancouver
900 West Georgia Street
Vancouver, B.C.

Media who wish to attend must register upon arrival and obtain accreditation by presenting press identification at the Saturna Island Room.

CONTACTS:

Media Relations
B.C. Ministry of Health
250 952-1887

Media Relations
Health Canada
613 957-2983

Scheffel, Emile HLTH:EX

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Sent: Tuesday, January 12, 2016 12:52 PM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX
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Over to you.....

Thank you!

Kirsty

Kirsty L Morris | Constituency Assistant

***Terry Lake, MLA Kamloops - North Thompson
Minister of Health***

Email: kirsty.morris@leg.bc.ca
Phone #: 250-554-5413 Fax #: 250-554-5417
Toll Free #: 1-888-299-0805
Website: www.terrylakemla.bc.ca



Be Green! Read from the screen

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January 11, 2016 1:51 PM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>; Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Cc: Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca>
Subject: RE: Mtg with MTL & Phoenix Centre

Great thx!

From: Morris, Kirsty L [mailto:Kirsty.Morris@leg.bc.ca]
Sent: Monday, January 11, 2016 12:29 PM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: Mtg with MTL & Phoenix Centre

Of course...I will let you know once arranged....

Kirsty L Morris | Constituency Assistant

Terry Lake, MLA Kamloops - North Thompson



Be Green! Read from the screen

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 11, 2016 11:12 AM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>; Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Cc: Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca>
Subject: RE: Mtg with MTL & Phoenix Centre

Could we leave scheduling to you and provide materials/staff from our end?

From: Morris, Kirsty L [<mailto:Kirsty.Morris@leg.bc.ca>]
Sent: Monday, January 11, 2016 11:11 AM
To: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: Mtg with MTL & Phoenix Centre

Good Morning All!

The following meeting request has been received in the CO from the ED of the Phoenix Centre which is located here in Kamloops.

MTL has reviewed the request this morning and agreed to this meeting.

As this is Health, let me know if you wish to take over arrangements for this meeting.

MTL has requested BN and staff for this meeting and he also wants Interior Health informing that he will be meeting with them in advance.

Let me know how you would like to proceed with the arrangements for this one.

Thanks Kirsty

Kirsty L Morris | Constituency Assistant

Terry Lake, MLA Kamloops - North Thompson
Minister of Health

Email: kirsty.morris@leg.bc.ca
Phone #: 250-554-5413 Fax #: 250-554-5417
Toll Free #: 1-888-299-0805
Website: www.terrylakemla.bc.ca



Be Green! Read from the screen

From: Sian Lewis [<mailto:sian.lewis@phoenixcentre.org>]
Sent: January 8, 2016 2:57 PM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>

I request a meeting with Hon. Dr. Terry Lake to discuss the *Supportive Transitional Living in Recovery* (STLR) pilot project. This program is specific to those who have recently completed the withdrawal management (detox) component of addiction treatment and require a supportive *living-in-recovery* community to maintain abstinence and engage fully in their ongoing treatment plan.

<http://www.phoenixcentre.org/supportive-transitional-living>

This project was initiated in the spring of 2013 with funding from United Way, Royal Inland Hospital Foundation and Stollery Foundation. This past fiscal, the program also received one-time funding from the Homelessness Partnering Strategy via the City of Kamloops. We are grateful to our funders for their two-year commitment and are now looking for permanent funding to ensure this program is sustained well into the future. We have approached our local health authority to request support, but currently there is no ability for them to commit financially to this program.

I understand the development of 'an additional 500 addiction spaces' (Ministry of Health, 2014/15 – 2016/17, Service Plan) falls within your portfolio; and I am hopeful this initiative aligns well with my objective to secure permanent funding for this critical health-focused transitional housing program. Phoenix Centre has been part of the regional review of the substance use continuum of care. We know sanctioned community-based supportive-living-in-recovery programs are cost efficient and effective.

- Approximate annual program cost is \$100,000.00 to support 11 clients in early recovery
- Program has been at full capacity since opening November 2013
- Clients are in a tenancy agreement; therefore pay their own living expenses (rent, food, etc.)
- We have tracked as much as a 83% decrease in these clients accessing emergency department, RCMP and/or ambulance services (specific to their substance use)
- STLR is part of the youth housing inventory managed by the A Way Home Committee and supported by the Wrap Force
- Allowable length of stay is not predetermined, but client stays range from 3 months to 12 months, with clients 'graduating' to permanent independent housing upon discharge
- Client successes include reaching sobriety milestones, securing employment, volunteering in the community, and/or entering into an educational program
- Our pre and post client surveys consistently reflect improvements in multiple life domains (physical & mental health, social & family relationships, education, employment, etc.)

Shelly Bonnah, with Interior Community Services will also attend this meeting to speak to the importance of STLR as it relates to youth housing. We look forward to meeting with Hon. Dr. Terry Lake. Please let us know when this can be arranged.

Warm regards,



Sian Lewis, MSW, RSW
Executive Director
Phoenix Centre™
Telephone: 250-374-4634
Fax: 250-374-4621
Sian.Lewis@phoenixcentre.org

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 12:32 PM
To: Paton, Arlene HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Sidhu, Manjit HLTH:EX
Subject: Re: in follow up regarding TasP for HIV and viral hep project

I think we're ok to send a letter although the announcement will come later unless Manjit has concerns regarding the process through finance.

T

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Paton, Arlene HLTH:EX
Sent: Tuesday, January 12, 2016 12:25 PM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Sidhu, Manjit HLTH:EX
Subject: FW: in follow up regarding TasP for HIV and viral hep project

Hi Minister – Julio Montaner has contacted me to ask for a funding letter so that he can get started on the hep C initiative, as he states he has received a note from you saying it's approved (please see his note below). The decision note you approved says you'll consider this \$5m as part of the year end funding discussions.

Please let me and Manjit know if you want us to proceed directly or wait to see the list of potential year end funding options.

Thanks -- and Happy New Year!

Regards,

Arlene Paton
Assistant Deputy Minister
Population and Public Health
Ministry of Health
PO Box 9646 Stn Prov Govt
Victoria BC V8W 9P1
Tel: 250-952-1731

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From: Dr. Julio Montaner [mailto:drjm@cfenet.ubc.ca]
Sent: Thursday, January 7, 2016 3:01 PM
To: Paton, Arlene HLTH:EX
Cc: Kendall, Perry HLTH:EX; McGowan, Gina HLTH:EX; O'Briain, Warren W HLTH:EX; XT:HLTH Day, Irene
Subject: in follow up regarding TasP for HIV and viral hep project

Dear Arlene, let me first thank you and Perry for hosting us earlier this week. We were very pleased to meet your colleagues and to share with them our work to date and some of the opportunities in front of us.

data, obviously as guided by the protocol. We need this before we can commit to the work, and develop the formal announcement and the timeline.

In this context, we discuss having a meeting next week. I think this would be a very important next step. I look forward to making this a priority.

I look forward to working with you expeditiously to get this project underway.

Very best regards, Julio

—
Julio S. G. Montaner, OC, OBC, MD, DSc (hon), FRCPC, FCCP, FACP, FRSC
Professor and Head, UBC-Division of AIDS
UBC and St. Paul's Hospital Foundation Chair in AIDS Research
Faculty of Medicine, University of British Columbia;
Director, BC Centre for Excellence in HIV/AIDS, St. Paul's Hospital, Providence Healthcare;
UNAIDS Special Advisor on HIV Therapeutics;
Past-President, International AIDS Society.

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January 12, 2016

Biology of tumour changes when childhood brain cancer recurs, Canadian study finds

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About the BC Cancer Agency

The BC Cancer Agency, an agency of the Provincial Health Services Authority, is committed to reducing the incidence of cancer, reducing the mortality from cancer, and improving the quality of life of those living with cancer. It provides a comprehensive cancer control program for the people of British Columbia by working with community partners to deliver a range of oncology services, including prevention, early detection, diagnosis and treatment, research, education, supportive care, rehabilitation and palliative care. For more information, visit www.bccancer.bc.ca.

-30-

For more information, please contact:

Suzanne Gold
The Hospital for Sick Children
416-813-7654 ext 202059
suzanne.gold@sickkids.ca

Kevin Sauvé
BC Cancer Agency
604-675-8257
kevin.sauve@bccancer.bc.ca



BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority

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January 12, 2016

Biology of tumour changes when childhood brain cancer recurs, Canadian study finds

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-30-

For more information, please contact:

Suzanne Gold
The Hospital for Sick Children
416-813-7654 ext 202059
suzanne.gold@sickkids.ca

Kevin Sauvé
BC Cancer Agency
604-675-8257
kevin.sauve@bccancer.bc.ca

Scheffel, Emile HLTH:EX

From: Lowe, Tracey HLTH:EX
Sent: Tuesday, January 12, 2016 2:11 PM
To: Scheffel, Emile HLTH:EX; Andrachuk, Andrea HLTH:EX; Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: RE: PCC mtg tomorrow

Thanks Emile, We will make Stephen aware of the topic. He has been invited to attend via telepresence by the Premier's office but we were not aware of the topic.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 2:04 PM
To: Andrachuk, Andrea HLTH:EX; Michell, Jennifer HLTH:EX; Lowe, Tracey HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: PCC mtg tomorrow

I'm advised it's on nurses bargaining – could you please make sure Steve is aware.

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 1:56 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: PCC mtg tomorrow

Hi Emile,

There is nothing in the DM's calendar and we've not been looped in. I will leave to Shaina to respond if there was any verbal indication.

Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 1:53 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: PCC mtg tomorrow

I'm sorry to ask so late – do we have any indication of agenda for PCC/MTL meeting tomorrow?

Thanks E

Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying

Final Report
November 30, 2015

Letter from the Co-Chairs

On behalf of our colleagues on the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group), we are pleased to submit this report of final key recommendations to the eleven participating provinces and territories, via the Ontario Minister of Health and Long-Term Care and Attorney General.

We have done our best, under challenging time constraints, to consult with as many stakeholder groups and individual experts as possible. Although physician-assisted dying is legal in many other jurisdictions, we believe we have come up with recommendations that will create a uniquely Canadian approach to this important issue.

The recommendations included are based on the best available evidence and the diverse expertise of the Advisory Group members.

Thank you for the opportunity to provide advice on this important issue.

Sincerely,

Dr. Jennifer Gibson
Co-Chair

Maureen Taylor
Co-Chair

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Acknowledgments

The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying wishes to acknowledge the 11 provinces and territories that came together with a vision of creating a pan-Canadian approach to physician-assisted dying. These partners provided vital support and feedback to our secretariat throughout the process and it has been a highly collaborative and rich experience.

We would especially like to thank the secretariat provided to us by the Ontario Ministry of Health and Long Term Care (MOHLTC) and the Ministry of the Attorney General. This team of bright individuals worked long hours, evenings and weekends, to coordinate, research, strategize and keep us to deadline. It cannot be easy to follow the track changes of nine editors, but they managed this without complaint. We are grateful for their patience, their guidance and their dedication.

Finally, our work could not have been accomplished without the individuals and groups across Canada, who shared their time, expertise, and experience with us. Although we heard a diversity of views and perspectives on how physician assisted dying should be implemented, we also observed a tremendous generosity of spirit and willingness to engage, understand and bridge across differences.

Foreword

Twenty years ago Sue Rodriguez asked “Whose body is this? Who owns my life?” Having been diagnosed with Amyotrophic Lateral Sclerosis, Rodriguez wanted the option of aid in dying when her suffering became unbearable. Her request to the Supreme Court of Canada was denied by a narrow margin in 1993, but since then polls have consistently demonstrated growing public support for the option of medically-assisted death. The highly visible efforts of Canadians such as Gloria Taylor, Kay Carter and Dr. Donald Low, to exercise control over their lives and deaths have contributed to a seismic shift – both legal and social – in our country’s approach to end-of-life decisions.

The Government of Quebec took the lead on this issue, launching extensive public consultations and non-partisan discussions which resulted in Bill 52 – *An Act respecting end-of-life care*. In Québec, physicians will start offering qualifying patients the option of medical aid in dying in December 2015.

The rest of Canada will not be far behind.

On February 6, 2015, the Supreme Court of Canada rendered its decision in *Carter v Canada (Attorney General)* (“Carter”).

The Supreme Court unanimously struck down the *Criminal Code* prohibitions against assisted dying to the extent that they prohibited physician-assisted dying for a competent adult person who (1) clearly

consents and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The Court held that the prohibition on physician-assisted dying deprived the claimants and others suffering from grievous and irremediable medical conditions of the right to life, liberty and security of the person. The Court further held that this prohibition was overbroad and could not be justified in a free and democratic society.

The declaration of invalidity was suspended for 12 months (until February 6, 2016) to allow federal, provincial and territorial governments to respond, should they so choose, by enacting legislation consistent with the parameters set out in the Supreme Court's decision. Complementing any potential federal response, each province and territory must decide whether to enact legislation and/or adopt policies to clarify the rules affecting the provision of physician-assisted dying in its jurisdiction in light of the Supreme Court's decision.

Stakeholders hold diverse opinions on physician-assisted dying. While the majority of Canadians are supportive of the *Carter* decision, the idea of physician-assisted dying remains ethically challenging for some. As well, important values are at stake (and potentially in conflict) with respect to various elements that comprise the proposed regulatory framework for physician-assisted dying. Acknowledgement of the differing ethical positions on physician-assisted dying in general and a careful ethical analysis of specific issues related to implementation must accompany the development of any policies, legislation and regulations.

Given this context, on August 14, 2015, eleven participating provinces and territories appointed a nine member Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying ("Advisory Group"). Participating jurisdictions include: Alberta, British Columbia (as an observer), Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut, Ontario, Prince Edward Island, Saskatchewan, and Yukon.

A federal External Panel, established to provide options for a federal legislative response to *Carter*, was recently asked to deliver a report by December 15, 2015, outlining feedback received to date, but without any policy advice or legislative recommendations. With this in mind, our report includes recommendations that ask provinces and territories to advocate for certain changes to federal legislation.

Overview of Recommendations

The Advisory Group is grateful to the large number of individuals and groups from across the country who shared their time, expertise, experience and advice with us as we developed our final recommendations. Below we provide an overview of our key recommendations.

Physician-assisted dying is a critical social policy issue for our generation. We believe strongly that the introduction of physician-assisted dying should be part of a larger discussion about high quality and

equitable access to end of life care in Canada. Specifically, we recommend that provincial, territorial and federal governments should work together to develop a pan-Canadian strategy for palliative and end-of-life care. This strategy would include physician-assisted dying as part of a continuum of services and supports to Canadians at the end of life.

Effective February 6, 2016, all provinces and territories must ensure access to physician-assisted dying. Provinces, territories, and the federal government, along with professional regulatory authorities, should work together toward the common goal of a harmonized, effective, and equitable regulatory framework for physician-assisted dying. This will involve an array of actions by a variety of government, regulatory, institutional and professional actors detailed in our report. A strong legislative response is essential.

Although the *Carter* decision refers only to physician-assisted dying, and we adopt this term in our report, the Advisory Group feels strongly that other health professionals – notably nurse practitioners, registered nurses and pharmacists – will need to be involved in the process of physician-assisted dying. Given increasing emphasis on interprofessional team practice as a standard of care in some settings, consideration of other health professionals will be necessary to ensure equal access and high quality of care. This is reflected in our recommendations.

Our recommendations place the patient at the centre. We have outlined a pathway for the provision of physician-assisted dying, including who should have access, how patients may request physician-assisted dying, how eligibility criteria should be assessed, and where physician-assisted dying may be provided. We recommend safeguards to protect vulnerable populations, including those who may face social factors that may impair a patient's ability to make a truly autonomous choice. These safeguards include assessment by two physicians, reflection to ensure all eligibility criteria are met, robust assessment of competency and consent, and a witnessed patient declaration form that serves as a formal request for physician-assisted dying.

The *Carter* ruling underscored the need to reconcile the interests of patients and providers. As we explain in this report, health care providers have the freedom to object to the provision of physician-assisted dying for reasons of conscience, but they are required to provide information about *all* end-of-life options, including physician-assisted dying. Conscientiously objecting health care providers are also required to either provide a referral, a direct transfer of care to another health care provider, or to contact and transfer the patient's records through a third party, agency or service which would have a duty to ensure the safe and timely transfer of care of the patient to a non-objecting provider.

Health institutions, including regional health authorities and other institutional providers (e.g., hospitals, hospices and long-term care facilities) are critical enablers of effective and equitable access to physician-assisted dying. Non-faith-based institutions should have an obligation to provide physician-assisted dying and faith-based institutions should have an obligation to either provide physician-assisted dying or make arrangements for a safe and timely transfer of the patient to a non-objecting institution. Regardless of how the process unfolds, we believe that there must be continuity of care for the patient.

It is essential for a properly functioning regulatory framework that there is robust and independent oversight: to monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. We recommend two levels of oversight: a Review Committee at the provincial/territorial level and a pan-Canadian Commission on End-of-Life Care at the national level.

Finally, physician-assisted dying is new to Canada. There is a need to build and sustain effective capacity, including through research and continuing quality improvement, health professional education and training, and public education and engagement.

List of Recommendations

Section/Sub-Section	Recommendations
End-of-Life and Palliative Care	
	Recommendation 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.
Collaboration and Coordination	
	Recommendation 2: Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.
Access	
Critical Enablers of Access to Physician-Assisted Dying	Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation. Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying. Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying. Recommendation 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing. Recommendation 7: Provinces and territories should request that the federal government amend the <i>Criminal Code</i> to explicitly protect those health professionals who provide

Section/Sub-Section	Recommendations
	supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying. Recommendation 8: Provinces and territories should request that the federal government amend the <i>Criminal Code</i> to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying. Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying. Recommendation 10: Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.
Pathway to Provision	
Request and Documentation	Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party. Recommendation 12: Provinces and territories should request that the federal government make it clear in its changes to the <i>Criminal Code</i> that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.

Section/Sub-Section	Recommendations
	Recommendation 13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid. Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient. Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request. Recommendation 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).
Assessment of Eligibility	Recommendation 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the <i>Criminal Code</i> that eligibility for physician-assisted dying is to be based on competence rather than age. Recommendation 18: "Grievous and irremediable medical condition" should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as "grievous and irremediable" should not be delineated in legislation or regulation. Recommendation 19: Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural

Section/Sub-Section	Recommendations
	safeguards have been respected. Recommendation 20: Physicians should use existing processes in the health care system to assess competency and consent. Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.
Review	Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met. Recommendation 23: Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment. Recommendation 24: For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used. Recommendation 25: We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.
Provision	Recommendation 26: We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual. Recommendation 27: Physician-assisted dying should be available wherever patients live (including in hospitals, long-

Section/Sub-Section	Recommendations
	term care facilities and at home), except certain conscientiously objecting facilities. Recommendation 28: There should be no requirement that a physician be present at a self-administered assisted death.
Reporting	Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures. Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.
Role of Conscientiously Objecting Health Care Providers	
Duty to Inform	Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs. Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner.
Duty to Care for the Patient	Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4.

Section/Sub-Section	Recommendations
Role of Institutions	
Duties of Institutions	Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision. Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission. Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.
Duties of Non Faith-based Institutions	Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.
Duties of Faith-based Institutions	Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.
Oversight	
	Recommendation 39: Provincial and territorial governments should establish a Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

Section/Sub-Section	Recommendations
	Recommendation 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-Life Care to provide system oversight and to report to the public.
Research and Continuing Quality Improvement	
	Recommendation 41: There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.
Health Professional Education and Training	
	Recommendation 42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.
Public Education and Engagement	
	Recommendation 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

INTRODUCTION

Advisory Group

Mandate

Our mandate is to provide non-binding advice to participating Provincial-Territorial Ministers of Health and Justice on issues related to physician-assisted dying. The advice is meant to assist provinces and territories in deciding what policies and procedures should be implemented within their jurisdictions in response to the Supreme Court's decision in *Carter*.

In developing our recommendations, our starting point was the *Carter* decision and we have (to the best of our abilities) provided recommendations that are consistent with the *Criminal Code*, the Canadian *Charter of Rights and Freedoms*, provincial/territorial Human Rights Codes and other applicable laws. We reviewed key health care policy questions related to, among other issues, eligibility criteria, conscientious objection, procedural safeguards, access and oversight. As part of this review, we invited written submissions from key stakeholder groups in the fields of health care, law and ethics, and from a range of patient, professional, regulatory and health care provider perspectives. We also sought extensive additional input and advice from targeted experts and stakeholders.

We recognize that provincial and territorial governments will retain final decision-making authority over whether to accept our recommendations and how physician-assisted dying should be implemented within their respective jurisdictions. This advice is not binding on participating or non-participating jurisdictions, and each government will maintain its authority to respond to the *Carter* decision as it deems appropriate.

Composition

Advisory Group members hold a wide variety of positions on physician-assisted dying and bring a range of professional expertise on key clinical, legal and ethical issues (see Appendix 1 for full biographies).

Jennifer Gibson (Co-Chair) - Director of the University of Toronto Joint Centre for Bioethics and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto

Maureen Taylor (Co-Chair) - Physician Assistant in Infectious Diseases and Medical Journalist

Doug Cochrane - Patient Safety and Quality Officer for British Columbia and Chair of the BC Patient Safety and Quality Council

Jocelyn Downie - Professor in the Faculties of Law and Medicine at Dalhousie University

Ruth Goba – Human Rights Lawyer/Commissioner, Ontario Human Rights Commission

Nuala Kenny - Professor Emeritus of Bioethics at Dalhousie University and Former Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada

Arthur Schafer - Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Trevor Theman - Registrar of the College of Physicians & Surgeons of Alberta

Karima Velji - President of the Canadian Nurses Association and Integrated Vice President, Mental Health Services, for London Health Science Centre and St. Joseph's Health Care London

Process

The Advisory Group conducted its work from late August to November 2015. This included four face-to-face meetings in Toronto and numerous teleconferences. Our work was informed by background briefings on physician-assisted dying and significant stakeholder engagement.

Background Briefings

Background briefings included:

- a legal analysis of the Supreme Court decision and a review of the division of powers with respect to law and health care between Canada's federal government and its provinces and territories;
- a comparative analysis of the implementation of physician-assisted dying internationally in Belgium, the Netherlands, Luxembourg, Switzerland, Oregon, Washington State and Vermont;
- a literature synthesis on key issues related to physician-assisted dying; and
- a review of publicly-accessible policy documents regarding physician-assisted dying from Canadian provider and other stakeholder groups.

Stakeholder Engagement

The Advisory Group engaged a broad range of stakeholder perspectives in two phases. In the first phase, we invited over 250 stakeholder groups in September 2015 to complete written submissions on a wide range of issues related to the implementation of physician-assisted dying in Canada. Invited stakeholders included: provider associations, professional regulators, faith-based groups, patient, social, and legal advocacy groups, health institutions, and academic and other groups (see Appendix 2 for a list of stakeholders consulted). Stakeholders provided input and advice on issues related to:

- eligibility criteria;
- procedural safeguards;
- the role of physicians and other health care providers;
- conscientious refusal by health care providers;
- the role of institutions;
- access issues;
- settings for the provision of physician-assisted dying; and
- case review and system oversight.

In the first phase, we also met with representatives from the Government of Québec to learn about that province's experience with public and stakeholder consultations, crafting legislation, and working with health care professionals, facilities and others on the implementation of physician-assisted dying, and with the Governments of Nunavut, Yukon and the Northwest Territories to gain an understanding of the unique issues of the northern territories regarding the implementation of physician-assisted dying.

In November 2015, the Advisory Group conducted a second phase of consultations to clarify specific implementation issues. The Advisory Group invited panel discussions (in-person or by phone) with experts and national stakeholders over two days in Toronto. These sessions brought together stakeholders with divergent positions on the implementation of physician-assisted dying and created an opportunity for meaningful dialogue between those holding conflicting views.

Deliberations

The Advisory Group comprised a diversity of perspectives on physician-assisted dying, which we sought to reconcile through our deliberations in light of the background briefings and stakeholder input. In some cases, this involved re-considering and sometimes putting aside deeply-held personal views to find common ground in the interest of Canadian patients and the public.

These recommendations represent our best advice for implementing a comprehensive system to respond to the decriminalization of physician-assisted dying in Canada.

We acknowledge that our recommendations will have to be revisited and may need to be revised upon action taken by the federal government in the near future. We urge provinces and territories to work closely with the federal government, with each other and with health professional regulatory authorities to ensure an efficient approach to planning, communication and implementation, as well as a harmonized regulatory framework. It is the Advisory Group's firm belief that synchronized regulation of physician-assisted dying is critical to the public interest.

We also recognize that time constraints may impede the full implementation of some recommendations by February 2016. However, we believe that it is incumbent upon provinces and territories to put in place a regulatory framework by February 2016 that best protects those who are vulnerable and ensures access for those who are eligible for physician-assisted dying.

Legal Context

Supreme Court Decision

Our recommendations were developed in response to the Supreme Court's decision in *Carter*. In its decision, the Court held that "Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." Where the above-noted criteria are met, the *Carter* ruling serves as an exception – for physician-assisted dying – to the general prohibitions in the *Criminal Code* against aiding and abetting a person to commit suicide and consenting to having death inflicted upon them.

It is notable that the Supreme Court did not limit the ruling to those unable to take their own lives, to cases of terminal illness, or to people near death. The Court's declaration is also not restricted to physical illnesses, diseases or disabilities, and includes mental illness.

The Supreme Court agreed with the British Columbia Supreme Court that the risks sometimes associated with physician-assisted dying – especially the potential risks to vulnerable people – "can be limited through a carefully designed and monitored system of safeguards." Although the Supreme Court did not outline the framework for such a system in the *Carter* decision, it expressed confidence that such a system could be implemented in Canada.

The Court noted that "nothing in its decision would compel physicians to provide assistance in dying", but also said that "the *Charter* rights of patients and physicians will need to be reconciled." The Court expressly left open the question of how to reconcile the rights of patients who seek physician-assisted dying with the religious or conscientious objections of physicians to participate in it. The Court was silent on the issue of whether institutions have any right to refuse to allow the provision of physician-assisted dying or otherwise participate in the provision of physician-assisted dying.

Several key terms were also left undefined in the Court's decision, including "adult" and "grievous." While the Court did not explicitly define "irremediable", the Court did clarify that "irremediable... does not require the patient to undertake treatments that are not acceptable to the individual."

Division of Powers

It is important to understand the federal and provincial/territorial division of powers to appreciate fully the context of our recommendations and any possible provincial/territorial action on physician-assisted dying.

In Canada, health is an area of shared federal and provincial/territorial jurisdiction. The federal Parliament may enact laws in relation to health care under its criminal law power (e.g., restricting

controlled drugs, prohibiting certain practices). The provinces and territories, on the other hand, may legislate in relation to health care with their powers over health insurance, the regulation of health professions, and hospitals.

If there is no inconsistency between a valid federal law and a valid provincial/territorial law relating to health, then both laws apply. In the event of an inconsistency between a valid federal law and a valid provincial/territorial law, the federal law applies and the provincial/territorial law is inoperative to the extent of the inconsistency. "Inconsistency" in this case means either that there is a conflict in operation between the two laws (e.g., the federal law says a person must do something while the provincial/territorial law says the person must not do that thing) or that the provincial/territorial law frustrates the purpose of the federal law.

The federal Parliament may (subject to the *Charter*) use its criminal law power to stipulate the circumstances under which physician-assisted dying is permitted and to prohibit physician-assisted dying in other circumstances. Provinces and territories cannot enlarge or restrict the circumstances in which physician-assisted dying is permitted beyond those validly provided for by Parliament. The criminal law power allows Parliament not only to enact prohibitions, but also gives Parliament a measure of regulatory authority as well. However, because there are some health matters of exclusive provincial jurisdiction, there is a limit to how detailed or "regulatory" the federal law can be. As outlined in the Supreme Court's reference to the *Assisted Human Reproduction Act*, criminal laws for the protection of health must address a "legitimate public health evil" rather than merely set uniform national standards for otherwise-beneficial medical activities. Parliament could establish physician-assisted dying rules aimed at reducing a risk of serious harm (e.g. rules ensuring that consent is unambiguous), but could not set medical standards unrelated to any risk of harm (e.g., Parliament could not regulate the referral or transfer-of-care obligations of physicians who object to physician-assisted dying on religious or conscientious grounds).

It is not possible to identify in the abstract a "bright line" past which valid federal criminal law turns into an invalid interference with provincial control over health. If the federal government sought to enact detailed regulations concerning the practice of physician-assisted dying (e.g., prescribing only certain permissible methods or drugs to be used in carrying out physician-assisted dying), it would need to be able to respond to any legal challenge to its regulatory authority by demonstrating with persuasive evidence that such regulations were aimed at addressing a legitimate public health evil. Provided that provincial/territorial laws were not inconsistent with valid federal legislation or with the *Charter*, provinces and territories could regulate aspects of physician-assisted dying not prohibited by federal law. For example, provinces and territories could enact legislation to regulate in relation to at least:

- eligibility (including rules regarding who may determine eligibility);
- determining competency and obtaining consent;
- safeguards to protect the vulnerable;
- settings in which physician-assisted dying is permitted;

- provider participation, including health institutions and both physicians and non-physician health professionals;
- means of delivery of physician-assisted dying;
- insurance (life and professional liability);
- certification of death; and
- reporting requirements and quality review.

Statement of Principles and Values

In developing our recommendations, we relied on a number of principles, values and existing rights, freedoms, responsibilities and obligations that exist in our health care systems. Some of these are enshrined in the *Charter of Rights and Freedoms* or provincial/territorial Human Rights Codes, while others are expressed in the Codes of Ethics of health care provider organizations. They all informed our work and form the basis for the recommendations in this report.

Individual and Institutional Rights and Duties

- The right to patient autonomy in end-of-life care decision-making
- The rights of freedom of conscience and religion
- The duty of health care providers to care for patients and not abandon them
- The right of Canadians to equitable access to health services
- The right to protection from discrimination as outlined in provincial Human Rights Codes
- The right to privacy
- When rights conflict, they must be reconciled

Pan-Canadian Principles

- Physician-assisted dying is one option in the end-of-life care continuum
- Canadians need access to high-quality palliative and end-of-life care
- Canadians need a harmonized system across the country
- Health care providers need clear guidance on rules, regulations and reporting requirements
- Transparency should be an ongoing goal whenever possible

In developing our recommendations, we also relied upon a set of beliefs with respect to regulation.

We believe that there are three critical actors in the regulatory system for physician-assisted dying: the federal government, the provincial/territorial governments, and the health professional regulatory bodies.

We believe that harmonization of regulation across jurisdictions is critical to the public interest and that an effective and efficient oversight system is essential to ensure responsible governance and trust in the regulatory system. A weak regulatory system would fail to meet the reasonable expectations of Canadians, including patients seeking physician-assisted dying and their loved ones.

We believe a strong legislative response is needed to ensure access to physician-assisted dying for all individuals who meet the eligibility criteria, to ensure that physician-assisted dying is provided only to individuals who meet the eligibility criteria, and to reconcile the sometimes competing interests of health care providers and institutions and patients (see Appendix 3 for a full list of recommendations that the Advisory Group believes should be implemented through

provincial/territorial legislation). We also believe that health professional regulatory authorities will play a critical role in the implementation of physician-assisted dying and their role in implementation will help to integrate physician-assisted dying into existing end-of-life processes and mechanisms (as much as possible and consistent with the physician-assisted dying legislation).

We believe that intergovernmental and cross-jurisdictional collaboration is essential. Of significance is the willingness by the new federal government to work collaboratively, as expressly set out in the Mandate Letter of the federal Minister of Justice, which urges the Minister to “lead a process, supported by the Minister of Health, to work with provinces and territories to respond to the Supreme Court of Canada decision regarding physician-assisted death.” We strongly encourage the provinces and territories to take up this invitation. Physician-assisted dying rests at the intersection of jurisdiction between the federal and provincial/territorial governments, as well as at the intersection of jurisdiction between the provincial/territorial governments and the professional regulatory authorities. Where there is a legitimate argument to be made that jurisdiction is shared or overlapping, we take the view that regulation should happen at the level with the greatest capacity for harmonization across the country, accountability, efficiency, and capacity for effective enforcement.

We believe the following three features are at the core of our call for a pan-Canadian regulatory framework:

1. Core elements established through the *Criminal Code*;
2. Additional procedural safeguards and provisions to ensure access established through provincial legislation (preferably based on a single model statute); and
3. Additional guidance for health care professionals established through their regulatory authorities (preferably based on model standards and guidelines developed collaboratively by the regulatory authorities).

Finally, we believe that physician-assisted dying should be integrated into existing end-of-life processes and mechanisms as much as possible. When faced with offering a new service, it can be tempting to create new systems to accompany the service. While physician-assisted dying is unique in some ways, it is also similar in many ways to existing procedures and can and should be treated as such. Physician-assisted dying should be treated as one appropriate medical practice within a continuum of services available at the end-of-life. Where we recommend different or additional processes or mechanisms, it is because we have concluded that they are necessary to appropriately balance the competing interests and values at stake and to ensure that the regulatory framework assures the trust of Canadians.

RECOMMENDATIONS

End-of-Life and Palliative Care

RECOMMENDATION 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.

Canadians need better access to quality palliative and end-of-life care, and should be made more aware of the options currently available to them. These were common refrains in the written submissions we received, the face-to-face consultations we conducted, and during our own deliberations.

Many provinces and territories have long been working to improve access to quality palliative and end-of-life care within their own jurisdictions. The Advisory Group strongly recommends that this work be expedited and that provinces and territories develop and implement a pan-Canadian strategy to ensure consistent standards and adequate resources for meeting what should be a national priority.

We also heard some stakeholders suggest that a patient could not truly give free or properly informed consent to physician-assisted dying without first being aware of and having access to adequate palliative care. The Advisory Group understands that the validity of patient consent lies at the heart of the assessment of eligibility for physician-assisted dying and that lack of access to quality palliative care might, in some specific cases, threaten various elements of a valid consent. However, withholding physician-assisted dying from everyone until palliative care is available and offered to all is not the appropriate response, as it denies those who are eligible the right to die in the manner they choose. Instead, society should work tirelessly to improve access to quality palliative care and health care providers should ensure that, in each individual case, any consent to physician-assisted dying is free and informed and made by a competent individual within the constraints of the system.

Despite our recognition of the importance of a pan-Canadian strategy for palliative and end-of-life care, we do not believe the implementation of physician-assisted dying should be delayed. We believe that a better approach is to ardently promote palliative care while ensuring that health care providers are aware of the potential concerns related to patient consent (to physician-assisted dying) and are equipped to effectively address these concerns while respecting patient autonomy. Better palliative care should not be seen as a pre-condition for the development of a system that permits physician-assisted dying, but rather as a complement to improved end-of-life care.

Collaboration and Coordination

RECOMMENDATION 2: Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.

Many stakeholders who spoke to the Advisory Group were concerned about the uncertain impact of physician-assisted dying on the health care system and the negative consequences for patients and the public of a patchwork of approaches across the provinces and territories. The introduction of physician-assisted dying across Canada will inevitably raise issues that cannot easily be anticipated by government working alone. Early and active engagement with all impacted areas of the health care system will be required to identify and resolve these issues quickly.

The Advisory Group believes that the successful introduction of physician-assisted dying in Canada will require coordinated action by a number of organizations and institutions with various responsibilities within our health care systems. Provinces and territories should reach out to these groups immediately to ensure that all policies and planned changes within each jurisdiction are well-aligned and understood and that gaps and challenges are identified as quickly as possible. Key stakeholder groups include health care provider associations, health care facilities and institutions, insurers, the Canadian Institute for Health Information, the Vital Statistics Council of Canada, clinical specialty groups, academic institutions (e.g., faculties of medicine, nursing and pharmacy), and accreditation bodies.

We direct the attention of provincial/territorial governments to the actions around which collaboration and coordination is necessary to create a comprehensive system for physician-assisted dying (See Figure 1).

Figure 1. Necessary Activities of Other Organizations and Institutions

Health Authorities
• Develop plans for enabling access (e.g., privileges, payment, managing transfers of care)
Associations of Health Care Institutions
• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law
Health Institutions
• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law • If faith-based and objecting to physician-assisted dying, develop plan for transfer of patients to another institution
Professional Associations
• Revise Codes of Ethics to be consistent with the law
Specialty Clinical Groups (e.g., Critical Care, Family Medicine, Palliative Care)
• Develop clinical practice guidelines for physician-assisted dying
Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, and analogous bodies for Registered Nurses (including Nurse Practitioners) and Pharmacists
• Develop physician-assisted dying competencies • Develop physician-assisted dying education programs
Accreditation Bodies
• Develop standards regarding physician-assisted dying for professional schools (e.g., Medicine, Nursing, Pharmacy) • Develop standards regarding physician-assisted dying for health care institutions
Professional schools (e.g., Medical, Nursing, Pharmacy, Social Work, Law, etc.)
• Develop undergraduate, postgraduate, and continuing education curricula and materials on clinical, legal, and ethical aspects of physician-assisted dying
Vital Statistics Council for Canada and Provincial/Territorial Registrars of Vital Statistics
• Revise “agreed data set” for reporting to the Canadian Institute for Health Information • Develop data access plan for Review Committees and researchers
Canadian Institute for Health Information
• Design data collection and access systems to flow information from governments to researchers in consultation with Canadian researchers as well as researchers who conduct the regular studies in permissive jurisdictions
Insurers (Health Professional Liability Insurers, and Life and Health Insurers)
• Develop explanatory materials regarding life insurance coverage • Develop explanatory materials regarding liability insurance coverage for health professionals

Access

Barriers to Access

During our stakeholder consultations, we learned that there are many reasons why patients within the same province or territory might not have equitable access to the same health services, some of which are common to many health care services and some of which may be unique to the provision of physician-assisted dying.

Representatives of territorial governments and northern/remote communities repeatedly raised the issue of geography and the uneven distribution of health care professionals. Rural communities can also suffer from inadequate health infrastructure or resources. These access issues are not unique to the provision of physician-assisted dying. Indeed, we anticipate that the challenges already associated with the delivery of adequate health care in certain areas of the country will present themselves with the introduction of physician-assisted dying as well.

The introduction of physician-assisted dying brings with it the possibility of unique barriers to access. These may include inadequate training of health professionals on its appropriate implementation, fear of legal liability among physicians and other health professionals, and issues of conscience. Some stakeholders raised the possibility that cultural factors may affect access to physician-assisted dying in some settings and fear of social stigma in small communities may dissuade health care professionals from participation in the procedure. Other impediments to access may include language barriers, concerns about professional liability insurance or life insurance policies, and the costs of physician-assisted dying services.

Critical Enablers of Access to Physician-Assisted Dying

In this section, we recommend a series of critical enablers of access that are specific to physician-assisted dying. However, we believe it is important to recognize that ongoing attempts to improve access to an array of health care services and supports will also help to provide effective access to physician-assisted dying.

RECOMMENDATION 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

RECOMMENDATION 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.

Physician-administered and self-administered physician-assisted dying is ultimately a communal responsibility of society, governments and health care professions. It should never rest solely on the

shoulders of individual health care providers or facilities. The burden of finding a physician or institution that is willing to assess and ensure eligibility and provide access to physician-assisted dying should never fall to the patient alone, regardless of their geographic location or whether they are in a hospital, hospice, or engaging with another part of the health care system.

We recommend the creation of a publicly-funded care coordination system to link patients with an appropriate provider of physician-assisted death. This system must be given the resources and legal authority necessary to ensure that patients do not face access barriers because of geography or physician supply or objection. This system would ensure that people in rural and remote communities have equitable access to physician-assisted dying (e.g., through physician visits and/or telemedicine services) and that those without a current primary care provider or with a conscientiously objecting physician still have the opportunity to receive care from a provider who will consider their eligibility for physician-assisted dying.

We recommend that this system be modelled on successful examples used in other health care services (e.g., cancer care, organ transplantation). We envision them as “patient navigators”, people who have an understanding of the field, knowledge of health care providers who are willing to provide physician-assisted dying to individuals who meet the eligibility criteria, and the interpersonal skills, resources, and legal authority to facilitate the transfer of care between health care providers (including the transfer of medical records so as to protect the identity of the health care providers accepting the patient). While the system’s initial role would be to connect patients to physicians and manage the transfer of patients, over time they may also assist with helping patients understand the range of end-of-life options available, including palliative care.

RECOMMENDATION 5: Provincial/territorial governments should publicly fund physician-assisted dying.

We believe that provincial/territorial governments should take steps to ensure that access to physician-assisted dying is not dependent on a patient’s ability to pay for the service. This will require that physician-assisted dying, including all aspects from counselling about end-of-life options to assessments and provision, are included as insured services under provincial and territorial health insurance plans.

RECOMMENDATION 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing.

Interprovincial billing agreements exist between provinces and territories for medically necessary insured hospital inpatient and outpatient services rendered in publicly-funded hospitals. All provinces and territories with the exception of Québec also participate in reciprocal billing arrangements for the payment of insured medically necessary physician services.

These agreements cover insured hospital and physician services for Canadians who are temporarily away from their province/territory of residence but are within Canada (e.g., travelling or on an approved absence for work or educational purposes). The agreements and the supporting billing system endeavour to ensure that the province or territory providing the service directly bills the patient's home province or territory, and that the patient is not required to pay directly for health services (provided the patient presents a valid health card). A small number of procedures have been placed on an exclusion list for interprovincial reciprocal billing. Physician-assisted dying is not analogous to the other services on the exclusion list and so should not be on this list.

While we recommend that all provinces and territories have a policy of providing access to physician-assisted dying, we recognize that in order to provide access to physician and hospital services in some rural and remote northern and border communities, there may be reliance on out-of-province/territory patient transfers and the interprovincial billing arrangements that support the related physician and hospital services. In addition, some individuals may wish to move from one province or territory to another for the last weeks or months of their lives in order to be near loved ones and caregivers. The Interprovincial Reciprocal Billing Agreement should not be allowed to create a barrier to access to physician and hospital services for them.

Our overall goal in making Recommendations 5 and 6 is to ensure that physician-assisted dying is an insured service for all eligible patients within Canada who qualify for publicly-funded health services. These recommendations would also mitigate concerns about international medical tourism within Canada, while still recognizing that some Canadian communities may not have the capacity to offer physician-assisted dying to their own residents, and that some patients may wish to move elsewhere within Canada towards the end of their lives.

RECOMMENDATION 7: Provinces and territories should request that the federal government amend the Criminal Code to explicitly protect those health professionals who provide supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying.

Our health care systems function best when teams of providers with diverse skills and scopes of practice work together to provide the best possible care for patients. The *Carter* decision permits physicians to provide physician-assisted dying within the circumstances of the decision, but is silent on the role of other health professionals. To ensure that all health professionals can provide quality care within their scope of practice as part of a team-based approach, we recommend that the federal government provide additional clarity in the *Criminal Code*. These *Criminal Code* changes should ensure that health professionals can provide the support services they normally would, including but not limited to a pharmacist dispensing a prescription, a nurse drawing medication into a syringe, or a personal support worker giving a patient prescribed medication.

RECOMMENDATION 8: Provinces and territories should request that the federal government amend the Criminal Code to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying.

While Recommendation 7 deals with the invaluable role other health professionals should be allowed to play in supporting the provision of physician-assisted dying, this recommendation deals specifically with the provision itself. Nurse practitioners have independent scope of practice to assess the patient and prescribe medication when appropriate. Where access to physicians or nurse practitioners is limited other regulated health professionals (registered nurses or, if applicable, physician assistants), acting under the direction of a physician, should be able to write the prescription or give the injection without exposure to criminal liability.

Given that, in the *Carter* decision, the Supreme Court referred only to physician-assisted dying, it will be important for any *Criminal Code* amendments to explicitly permit regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners, to facilitate adequate access across Canada. Without this clarity, non-physician professionals would face uncertainty about their role and would potentially be exposed to liability for providing physician-assisted dying. It will be essential that provincial/territorial scope of practice legislation does not create barriers to these health professionals providing physician-assisted dying.

Throughout this report, our recommendations refer to physicians when discussing the provision of physician-assisted dying. If the *Criminal Code* changes advocated for in this recommendation are adopted, these recommendations should be read to include regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners.

RECOMMENDATION 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

We view the appropriate protection of health care providers from liability as a way to promote access to physician-assisted dying. We heard from many stakeholder groups that if health professionals feel they are exposed to liability, they will be much less likely to provide physician-assisted dying.

This recommendation has two aspects. First, provinces and territories should ensure that necessary legislative or regulatory amendments are made to codify this protection. Health professionals who provide physician-assisted dying need to know that their participation will not expose them to liability as long as they are not negligent and act in good faith within the rules set out to support the implementation of physician-assisted dying. Second, provinces and territories should ensure that health care providers' liability insurance does not discriminate against providers based on whether or not they provide physician-assisted dying. Provinces and territories should work with the Canadian Medical Protective Association and other insurers of health professionals, and make any necessary legislative or regulatory changes to ensure that liability coverage is not affected by whether the provider participates in physician-assisted dying.

RECOMMENDATION 10: Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.

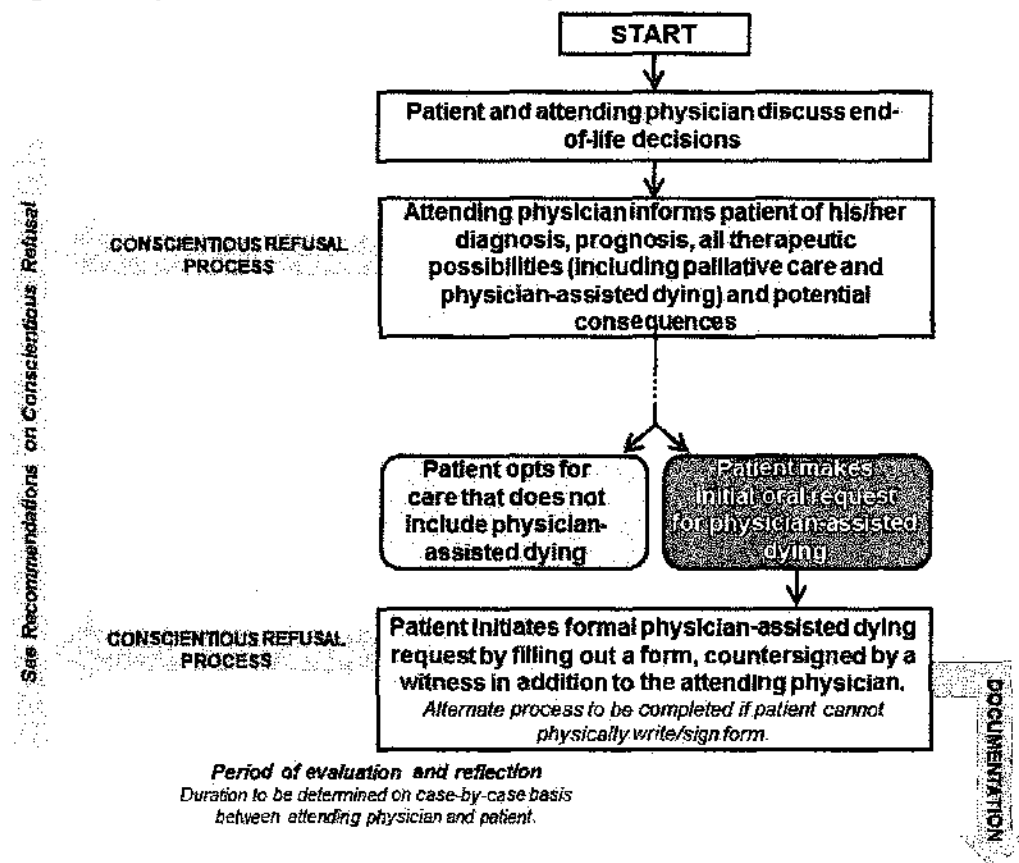
Life insurance payments can be critically important to beneficiaries after a patient has died. Provinces and territories should ensure that beneficiaries do not have life insurance claims rejected solely on the grounds of the benefactor receiving physician-assisted dying.

Pathway to Provision

In this section, we outline the process by which a patient may initially discuss their end-of-life options, request physician-assisted dying, go through a rigorous assessment process, and then, where the eligibility criteria are met and procedural safeguards observed, be provided with physician-assisted dying. Throughout this section, we will highlight areas where we have added additional safeguards to existing processes to protect patients and ensure that consent for such an important decision is free and informed and made by a competent individual. Graphical depictions of our proposed patient pathway are included throughout this section. A full version is included as Appendix 4. The pathway below describes the most common scenario; however, a modified approach may be required in some cases. Once we have outlined the standard patient pathway, we will examine the role of health care providers and faith-based institutions who object to physician-assisted dying for reasons of conscience.

Request and Documentation

Figure 2. Request and Documentation Pathway



The patient-physician relationship is founded on mutual trust, respect, knowledge, and understanding between the patient and his or her health care provider. Through the relationship, the physician gains a

medical and psychosocial understanding of the patient and the reasons for his or her wishes with respect to health care. This relationship is the basis for assessments of competency, knowledge of the medical condition or conditions affecting the patient, and the impact and natural evolution of potential treatments. This relationship provides the patient with an understanding of his or her condition and treatment options and provides the physician with the knowledge needed to assess the patient's competency in making a request for physician-assisted dying. This relationship may take time to develop.

In the context of the patient-physician relationship and the principles of their profession, health care providers have several duties that apply regardless of their personal position on physician-assisted dying. These duties include the duty to inform, the duty to care for patients, and the duty of non-abandonment. In practice, this means that any physician has a duty to discuss all end-of-life options with their patients, including physician-assisted dying, even if they themselves would not be willing to participate in it.

When a patient raises the issue of physician-assisted dying, his or her physician should engage in a meaningful dialogue with the patient on diagnosis, prognosis, all end-of-life options (including palliative care and physician-assisted dying) and their potential consequences. If the patient is willing and agrees, these conversations should also involve the patient's family and caregivers. Based on these discussions, if the provider is willing to participate in physician-assisted dying, they should move on together to the next step on the pathway. If the physician is unwilling to participate, or if in an institution that does not provide physician-assisted dying, the physician should trigger the conscientious objection process (see Recommendations 31-38 below).

Revocation

The patient can, at any time, rescind his or her request for, or consent to, physician-assisted dying either verbally or in writing.

Patient Declaration Form

RECOMMENDATION 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

The patient declaration form, developed by provinces and territories or an oversight body established by provinces and territories, must clearly state that the patient has been informed about his or her condition and all available options, understands the information and appreciates the consequences of the decision, and has requested physician-assisted dying. If the declaration is being completed before the patient is experiencing enduring intolerable suffering, it must also include a statement clearly explaining what the patient considers to constitute enduring intolerable suffering.

The patient declaration form must be signed by the patient and countersigned by an independent witness and the attending physician. Where a patient cannot physically write or sign the patient

declaration form, an alternative means may be used, such as a video recording. A documented patient declaration witnessed by an independent party will serve as formal confirmation of the patient's wishes and a means of providing assurances to the attending physician and other interested parties that the patient has clearly requested and consented to physician-assisted dying.

Timing of Completion of Declaration

RECOMMENDATION 12: Provinces and territories should request that the federal government make it clear in its changes to the Criminal Code that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.

RECOMMENDATION 13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid.

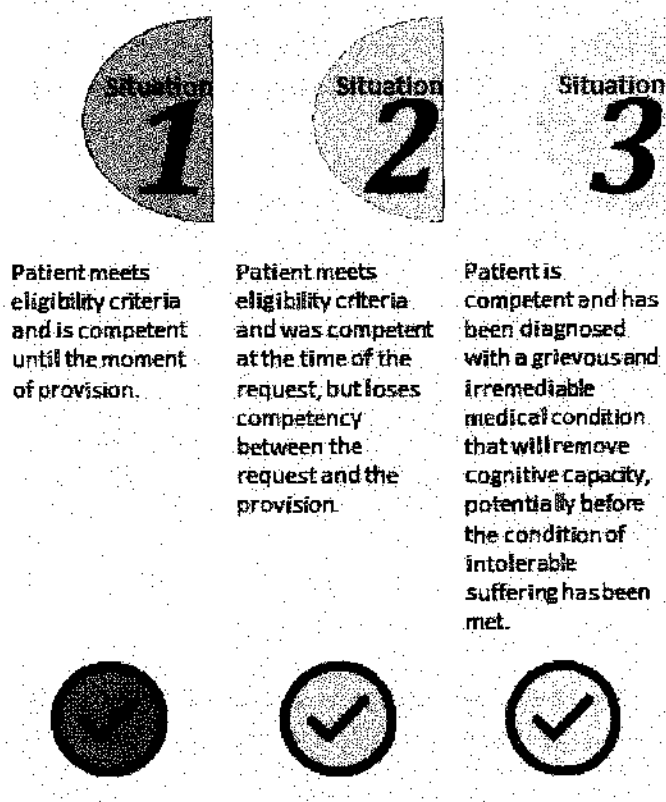
We have carefully considered the question of when the requirement for competency must be met. We have considered four possibilities and determined that physician-assisted dying should be permitted in three of those situations.

Provinces and territories should advise the federal government to make clear in the *Criminal Code* that physician-assisted dying is permissible where:

- a) the patient is competent at all times from the initial request to the moment of provision of assistance;
- b) although competent and having a grievous and irremediable condition and experiencing intolerable suffering at the time of the completion of the patient declaration form, the patient lost competence between the completion of the patient declaration form and the provision of assistance; or
- c) although competent and having been diagnosed with a grievous and irremediable condition, but not yet experiencing intolerable suffering, at the time of the completion of a patient declaration form, the patient lost competence between the completion of the patient declaration form and the onset of the enduring intolerable suffering.

We note that *Carter* requires that physician-assisted dying be provided to a competent adult. Scenario (a) above is clearly allowed under the Supreme Court of Canada's decision. However, the Supreme Court's decision is silent on scenarios (b) and (c) above.

Figure 3. Timing of the Completion of a Declaration



The first situation is the most straightforward: a patient who has a grievous and irremediable condition and is experiencing intolerable suffering and is competent until the moment of provision. This person should qualify for physician-assisted dying.

The second situation involves a patient who, although competent and having a grievous and irremediable condition and experiencing intolerable suffering at the time of the completion of the declaration form, loses competency between the completion of the form and the provision. In this case, we believe that the person should be eligible for physician-assisted dying.

The third situation is more complex. It may occur when a patient has been diagnosed with a condition that will remove

competency, such as dementia, and has concerns about the quality of his or her end-of-life in that future. The patient is not experiencing intolerable suffering, but has been diagnosed with a grievous and irremediable medical condition. Should this patient be permitted to complete a patient declaration indicating that he or she would like to receive physician-assisted dying when certain conditions that the patient believes would constitute enduring intolerable suffering are met, even if the patient will no longer be competent when those conditions are met? Our answer is yes.

Particularly for certain degenerative diseases, we feel that to require that these patients be competent at the time physician-assisted dying is delivered would force many of them to trigger the act earlier in the course of their disease than necessary. Some people may be more comfortable with their diagnosis knowing that physician-assisted dying will be available to them after they lose competency. In such cases, physicians will need to take extra care to ensure that the patient understands and freely consents to his or her decision. The physician and patient should discuss the normal progression of the disease and how patients often respond and adapt to the disease. These conversations should continue throughout the progression of the disease (or up to the point of losing competence) to assess and confirm that the patient maintains his or her decision with respect to the future provision of physician-assisted dying.

We recognize that rules about advance directives vary across the country and, therefore, where a patient wishes to consent to physician-assisted dying in advance, the Advisory Group recommends that a standardized patient declaration form requesting physician-assisted dying be used instead of existing mechanisms. The patient's symptoms and/or presentation at the time of the provision of the assistance will need to be assessed against the criteria for intolerable suffering set out by the patient in advance.

There is a fourth, possible situation that we considered which involves a person who has not yet been diagnosed with a grievous and irremediable medical condition, but has completed a patient declaration form. We did not come to agreement on whether such a declaration should be considered valid consent for the purposes of eligibility for physician-assisted dying. Some members of the Advisory Group believe that this is consistent with existing practice with respect to advance care directives and so should be permitted, while others believe it is not possible to give informed consent to physician-assisted dying prior to a diagnosis of a grievous and irremediable medical condition. We therefore recommend that provinces and territories work with the federal government to consult further on this issue within the coming year and update legislation if needed by February 2017.

Substitute Decision-Makers

RECOMMENDATION 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Many stakeholder groups emphasized the paramount importance of patient autonomy as justification for respecting requests for physician-assisted dying. Allowing substitute decision makers to authorize/consent to this procedure on behalf of a patient leaves open the possibility that a patient's life could be ended in contravention, or without the explicit knowledge, of his or her wishes.

Patient Information Form

RECOMMENDATION 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

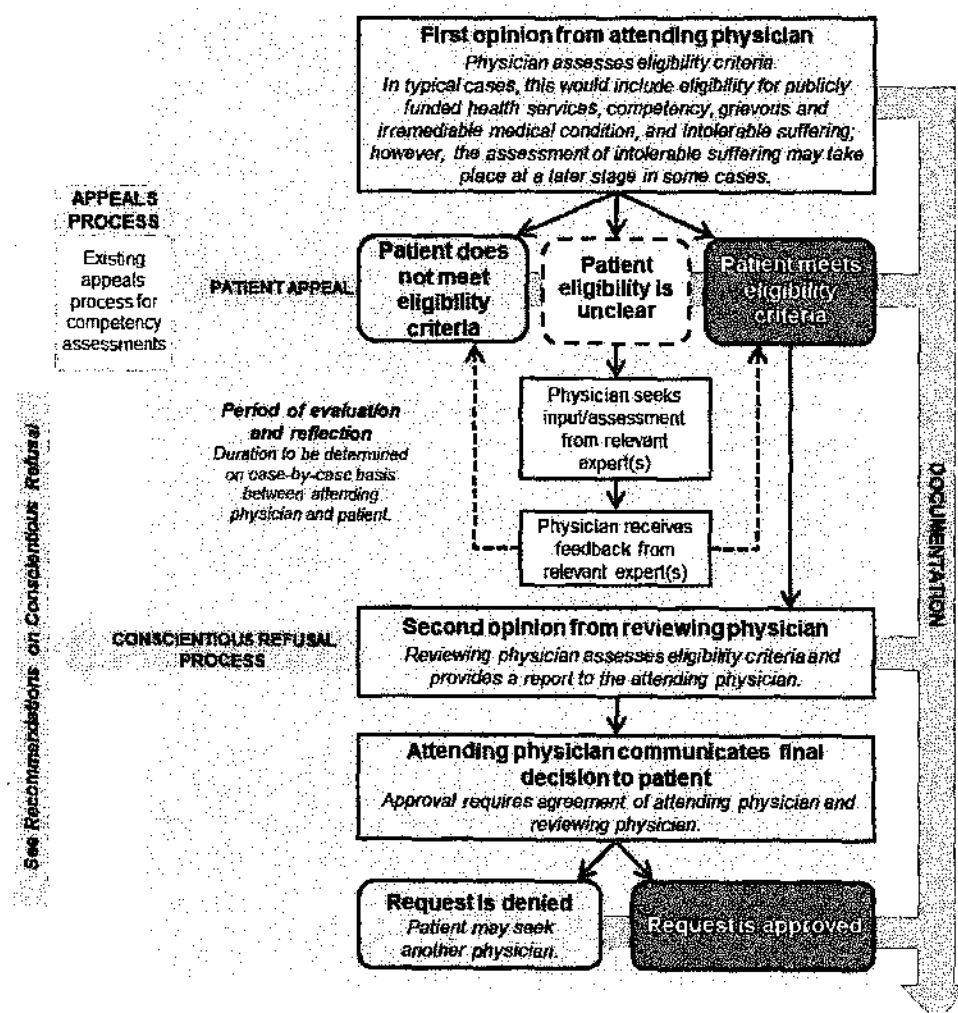
Patients who request physician-assisted dying should be asked to complete a simple form that outlines demographic information and their reasons for requesting physician-assisted dying. This information will be required by provinces and territories as part of an oversight system to be outlined later in this report. The de-identified information will also be relevant to researchers who choose to study the implementation of physician-assisted dying in Canada.

RECOMMENDATION 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).

Data should be collected from the patient's initial request to the time of signing the death certificate. In addition to the data gathered through the declaration form and information form, data should also be collected on the number of, and grounds for, refusals of patient requests for physician-assisted dying and the number of patients permitted physician-assisted dying that chose not to proceed. Data should be gathered by the attending physician as part of the request and assessment process and provided to the Review Committee and Oversight Body, outlined below.

Assessment of Eligibility

Figure 4. Assessment of Eligibility Pathway



The willing attending physician must ensure that the patient is eligible for physician-assisted dying based on the eligibility criteria set out in the *Carter* decision. According to the Court, a patient must be 1) an adult person 2) with a grievous and irremediable medical condition (including an illness, disease or disability) 3) that is causing enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The court also required that the adult person be competent and clearly consent to the termination of life.

Adult Person

RECOMMENDATION 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the Criminal Code that eligibility for physician-assisted dying is to be based on competence rather than age.

The *Carter* decision applies to a “competent adult person,” but does not include a definition of adult. In assessing whether someone is an adult person, an arbitrary age limit such as 18 years old provides no valid safeguard. Instead, it is important that willing physicians carefully consider the context of each request to determine whether the person has the information needed, is not under coercion or undue pressure, and is competent to make such a decision.

Competence and consent to treatment laws vary among provinces and territories. In some cases, decisional competence is based on age, but in others, age is irrelevant to whether the patient has the legal authority to make decisions about his or her treatment.

An ideal regulatory framework for physician-assisted dying would have uniform eligibility rules. Indeed, many provider groups asked the Advisory Group to recommend a consistent national approach to eligibility for physician-assisted dying and patient advocacy groups also sought an easily understandable criterion for accessing the service regardless of where in the country a patient lives. The federal government could facilitate this by affirming that the definition of “adult” in the context of physician-assisted dying relates to a patient’s ability to give consent rather than a particular age cut-off. That is, to allow access to patients who are competent, regardless of age.

Grievous and Irremediable Medical Condition

RECOMMENDATION 18: “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation.

RECOMMENDATION 19: Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural safeguards have been respected.

The second aspect of eligibility requires that the physician confirm that the patient is suffering from a grievous and irremediable medical condition. The Supreme Court does not offer a definition of “grievous” in the *Carter* decision. The Canadian Oxford Dictionary defines “grievous” as “very severe or serious.” This definition should be used in any changes proposed to the *Criminal Code*, provincial/territorial legislation or regulatory authority standards related to physician-assisted dying. Consistent with the *Carter* decision, we understand that “irremediable” is used to describe a condition that cannot be alleviated by any means acceptable to the patient. The determination of whether a condition is irremediable should be a two-step process. First, the physician must determine whether any treatments exist for the condition. Second, the patient must determine whether any of the available treatments are acceptable to him or her.

We heard consistently through the stakeholder engagement process that grievous and irremediable should not be defined in terms of specific health conditions. No list of specific conditions could capture the range of illnesses, diseases and disabilities that might meet the parameters established by the Supreme Court. Instead, we recommend that regulatory authorities develop tools to assist physicians in making this determination on a case by case basis.

Intolerable Suffering that is Enduring

The Supreme Court states that the medical condition must cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition. This is a subjective test based on the patient’s response to his or her condition. In order to determine whether this eligibility criterion has been met, the physician must receive from the patient a very clear statement of what the patient considers or would consider to be suffering that is intolerable.

Competency and Consent

RECOMMENDATION 20: Physicians should use existing processes in the health care system to assess competency and consent.

During our consultations, we heard from some stakeholder groups who felt that a panel of doctors, a tribunal or judge, or a specially-trained professional should be required to conduct a vulnerability assessment for all persons with disabilities seeking physician-assisted dying. We also heard that a mental health assessment should be required for all persons seeking physician-assisted dying.

We share these group’s concerns about the protection of vulnerable populations and the need for safeguards to do so. However, our research and discussions lead us to believe that existing mechanisms

are sufficient to ensure that patients are making an informed choice and that physicians can effectively assess patient competence. In the text that follows, we describe the current systems in place to support informed consent and competency assessment and show how these systems can be applied to the implementation of physician-assisted dying.

Informed Consent

To be valid, consent must be free and informed. To be free, the person making the choice must not be subject to coercion or undue pressure. For consent to be informed in the context of physician-assisted dying, we follow the Federation of Medical Regulatory Authorities of Canada's advice in their June 6, 2015, guidance on physician-assisted dying:

The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, and alternatives, including comfort care, palliative and hospice care, pain and symptom control and other available resources to avoid the loss of personal dignity. The physician must advise the patient of any counselling resources that are available to assist the patient. The attending physician must inform the patient of his or her right to rescind the request at any time. The attending physician has an obligation to take reasonable steps to ensure that the patient has understood the information that has been provided.

Competency

To be competent to consent to treatment, the person must be able to understand information relevant to the decision and appreciate the nature and consequences of the specific decision being made or not made. Competence can fluctuate over time and a person may be competent for one decision (e.g., simple with minor consequences) but not another (e.g., complex with very serious consequences).

Assessment

In most cases where a person requests physician-assisted dying, there will be little doubt that his or her decision is free and informed and that the patient has the competence to make the decision to choose physician-assisted dying. In other cases, competency may be in question and there may be reason to doubt whether the decision is free and/or informed. Particular concerns that have been raised include those involving persons with psychiatric conditions, minors, and persons living with severe disabilities. For example, we heard concern from some stakeholders that individuals with psychiatric conditions or minors may not be capable of appreciating the consequences of the decision because of their mental condition or lack of life experience and not-yet-fully developed executive functions. There were those who felt individuals living with severe disabilities may be particularly vulnerable to coercion or make the choice because of a lack of social supports and few other options. As a consequence, some suggested that age, psychiatric illness, and disability should be exclusion criteria for access to physician-assisted dying (or should be subject to different regulatory requirements).

Governments undoubtedly have an obligation to protect individuals who might seek physician-assisted dying while they are not capable of making an autonomous choice. However, we do not feel those who fall into these categories should automatically be denied the right to access physician-assisted dying.

Instead, we acknowledge the need for heightened scrutiny during assessments of the eligibility criteria for physician-assisted dying in the face of any signals that might indicate compromised autonomy (including, but not limited to psychiatric illness, disability, or age). Just as they already do for other end-of-life decisions, where a health care provider has concerns, doubts, or uncertainty about whether an individual is competent and is making a free and informed choice, the provider should take whatever time and consult any additional experts as is necessary to reach the conclusion that the person does or does not meet the eligibility criteria. Health care providers must assess the components of a valid consent on a regular basis and often in circumstances in which the decision is complex and the consequences dire. The same skills (and time and additional expertise) that are used for assessing the elements of informed choice for other end-of-life decisions are transferable and adequate for making such assessments for the physician-assisted dying decision.

Although we do not recommend the use of age, psychiatric condition, or disability as exclusion criteria for access to physician-assisted dying (as described in Recommendation 18), we do recommend the development of better assessment tools for consent and competency (especially in relation to vulnerabilities associated with lack of social support for persons living with disabilities). We also recommend the development and implementation of educational materials designed to improve the capacity of health care providers to assess competency – particularly in the presence of potentially compromising conditions or social contexts. This approach will serve the objective of protecting individuals who might seek physician-assisted dying but are not capable of making an autonomous and informed choice. It will also have the added benefit of protecting individuals who might make other life-limiting decisions while not capable of making an autonomous choice (e.g., refusing life-sustaining treatment in the face of a traumatic injury).

Insured Persons

RECOMMENDATION 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

In addition to the criteria set out in the Supreme Court’s decision in *Carter*, we believe that only patients who are eligible for publicly-funded health services should be considered eligible for physician-assisted dying. The *Carter* decision does not include citizenship, residency, or status as an insured person as an eligibility criterion for access to physician-assisted dying, but almost all jurisdictions where physician-assisted dying is legal limit access to the service in this manner. Although imposing a Canadian residency requirement would prevent residents of foreign countries from visiting Canada to receive physician-assisted dying, imposing limits based on citizenship or permanent residency status could also create a barrier to access for some in Canada. As a result, we recommend that all – and only – those eligible for publicly-funded health services also qualify for physician-assisted dying.

Review

Second Assessment

RECOMMENDATION 22: Two physicians must assess the patient to ensure that all criteria are met.

Patients who are enduring intolerable suffering and who meet all other eligibility criteria for physician-assisted dying should not have their suffering extended or compounded by an unnecessarily burdensome administrative process to access this service. We feel, however, that the approval of an attending and reviewing physician (or nurse practitioner acting within their scope of practice) is a reasonable safeguard to help ensure that a patient has indeed met the eligibility requirements for accessing physician-assisted dying and an appropriate step to help support the attending physician.

Following the request for physician-assisted dying and assessment of eligibility and competency by the attending physician, we recommend an additional safeguard be put into place for physician-assisted dying whereby a second physician assesses the patient for eligibility and provides a report to the attending physician. For this to be justifiable hurdle, and not an unjustifiable barrier, this recommendation is conditional upon our earlier recommendation that Criminal Code changes make it possible for other regulated health care professionals – in addition to physicians – be permitted to provide assistance in dying (see Recommendation 8).

RECOMMENDATION 23: Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment.

While we recommend that two physicians should be involved in ensuring that all criteria have been met, we recognize that some communities do not have access to local physicians at all. In these cases, provinces, territories or the regional health authorities should work to provide patients with access to physicians either through telemedicine, by bringing physicians into the community or, if the patient is willing, by transporting him or her to an area where physicians are available and willing to conduct the necessary evaluations.

Appeals and Dispute Resolution

RECOMMENDATION 24: For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used.

Existing provincial/territorial mechanisms allow patients to appeal decisions related to competency and set out the circumstances in which a patient has a right to appeal. For example, in Ontario, if a physician

has determined that a patient is not competent to consent to treatment, the patient has the right to appeal to the Consent and Capacity Board. No new system to handle competency disputes is required for physician-assisted dying.

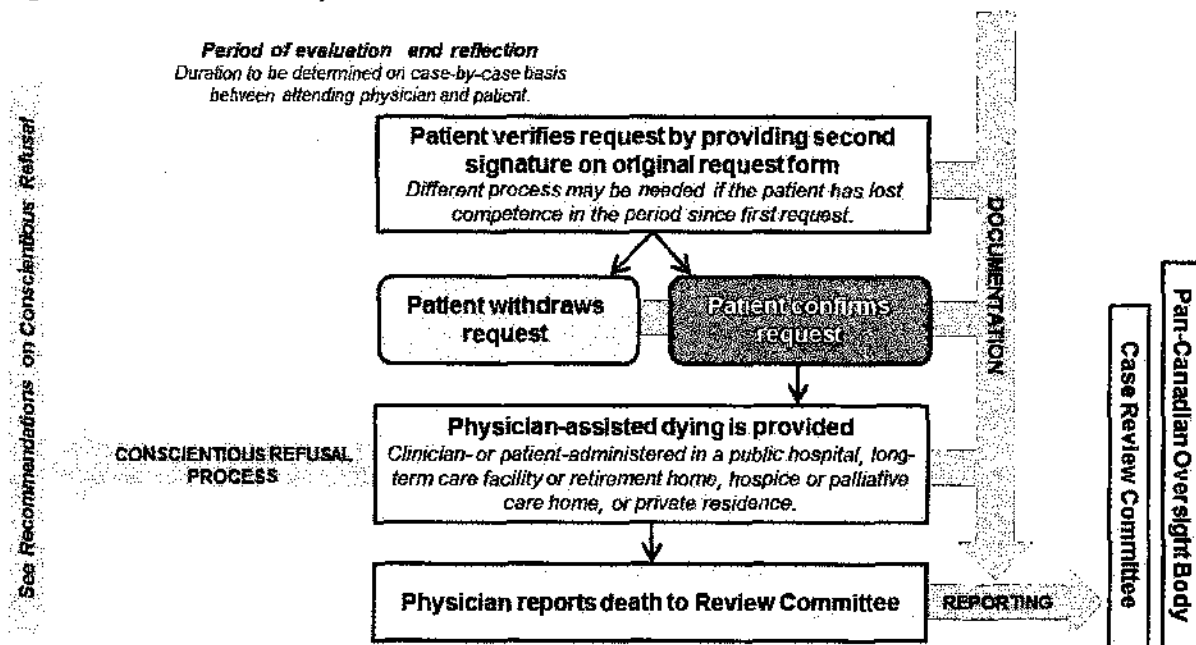
RECOMMENDATION 25: We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.

We do not feel it necessary to set up an appeals process when the attending or reviewing physician concludes that the eligibility criteria (other than competency) have not been met. Instead we recommend the following:

- If the attending physician determines that the eligibility criteria (other than competency) have not been met, the attending physician shall inform the patient of the reasons for that determination. The patient should not be precluded from consulting another physician.
- If the reviewing physician determines that the criteria (other than competency) have not been met, the reviewing physician shall inform the patient and attending physician of the reasons for that determination. The attending physician or patient should not be precluded from seeking the opinion of another reviewing physician.

Provision

Figure 5. Provision Pathway



Once the reviewing physician has confirmed that the eligibility criteria have been met, the attending physician may request that the patient re-confirm his or her intention (if the patient is still competent) and the physician may provide physician-assisted dying to the patient.

RECOMMENDATION 26: *We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual.*

Several stakeholder organizations have requested that governments be prescriptive in setting out a specific waiting/reflection period as part of a clearly articulated physician-assisted dying process. Others have suggested this would not respect patient autonomy and physician judgement. While a mandated waiting/reflection period has been established in some jurisdictions, such as in the U.S. states that offer physician-assisted dying, we believe that such an approach would impose an arbitrary barrier to access that would negatively impact both patient decision-making and physician judgement.

Furthermore, a specific time period serves as a poor proxy for detecting decisions that are either not fully informed, not voluntary or made when a patient is not capable of fully appreciating the consequences of the decision being made. In some cases, a set time period may be too short for the physician to make a confident assessment of the elements of a valid consent. In other cases, it may be longer than is necessary.

As such, we do not recommend a particular prescribed time period. What is essential is that the patient has sufficient time to come to an informed and voluntary decision, to understand the information, and appreciate the consequences of his or her decision, and that the physician has had sufficient time to come to the conclusion that all of the eligibility criteria have been met. The time required to meet these conditions will vary depending on circumstances and so a set amount of time would be arbitrary. Furthermore, the passage of at least some time in every case is assured by the requirement that the attending and reviewing physicians both be confident that the consent is free and informed and made by a competent individual.

RECOMMENDATION 27: Physician-assisted dying should be available wherever patients live (including in hospitals, long-term care facilities and at home), except certain conscientiously objecting facilities.

Increasingly, Canadians express the desire to die in their own home and we believe both physician-assisted dying and palliative care should be delivered in the home if that is the patient's wish. In some cases, a patient's home may be a retirement facility, nursing home or hospice.

RECOMMENDATION 28: There should be no requirement that a physician be present at a self-administered assisted death.

Patients should have the right to choose who is present at their time of death. Therefore, there should be no requirement that a physician (or nurse practitioner acting within the scope of their practice) be present at a self-administered physician-assisted death. We recognize that self-administered physician-assisted dying may result in more complications than physician-administered physician-assisted dying. However, patients should be free to determine for themselves whether the benefits to them of allowing self-administration without a physician present outweigh the potential risks. Self-administration without a provider present may lead to more complications and adverse events, but research from other jurisdictions indicates that these events are extremely rare. Physicians should ensure that the potential risks are clearly explained to the patient and provide instructions on how to respond to them should they materialize.

Reporting

Case Review

RECOMMENDATION 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Although we do not support case review before provision of physician-assisted dying (as outlined in Recommendation 20), we believe that a regular review of individual cases after provision is required to confirm that all procedural safeguards have been followed correctly and to identify any systemic problems as soon as possible. Within 14 days of the provision of the assistance (either through the writing of a prescription or direct provision by a health care provider), the attending physician must file a report with the Review Committee (for details on the makeup and mandate of the Review Committee, see Recommendation 39). The Review Committee should have access to all patient files including the patient declaration form, patient information form, attending and reviewing physician's reports and additional competency assessments (if undertaken). Provinces and Territories should undertake any legislative or regulatory changes required to ensure that such health information can be shared with the Review Committee.

Vital Statistics

RECOMMENDATION 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.

Listing physician-assisted dying on medical certificates of death may require legislative changes in some jurisdictions, but we believe that it is an important step for tracking and data collection purposes to ensure full transparency. Physician-assisted dying should be listed as the manner of death. The name of the medical condition that qualified the person for physician-assisted dying should be reported as the underlying cause of death. The injection or ingestion of drugs should be recorded as an antecedent cause.

Provinces and territories should direct their Vital Statistics registrars to work together to ensure a common approach is used across Canada to ensure that system oversight can be efficient and effective (See Recommendations 39-40 regarding oversight).

Role of Conscientiously Objecting Health Care Provider

We have already outlined the process for the provision of physician-assisted dying when there are no conscientious objections being raised. We have also highlighted the duties and obligations of all health care providers, whether or not they object to the provision of physician-assisted dying. These duties include the duty to provide full information about all end-of-life options, including physician-assisted dying, the duty to care for the patient in a non-discriminatory manner and the duty of non-abandonment of the patient until such a time as care has been transferred to another provider.

These duties must be fulfilled by a conscientiously objecting health care provider. While we believe that there is a communal responsibility to provide access to physician-assisted dying, individual providers are not absolved of their personal/professional responsibilities, particularly in a publicly-funded system.

We believe that the positions set out below represent a respectful reconciliation of the many competing values at stake in the context of physician-assisted dying.

We believe that this reconciliation of competing values also harmonizes the approach taken across health professions (i.e., nurses' consciences are not given less weight than physicians'). We also believe that the burden of the risk of lack of access should not fall on patients. We believe that the burden of the risk of failure to ensure the design, implementation and maintenance of a system for arranging transfers of care from providers and institutions that object to providing physician-assisted dying should rest on those with the greatest power and voice to ensure that the government and other organizations design, implement, and maintain an effective and efficient transfer of care system (i.e., health care providers, professions, regulators and institutions rather than patients with grievous and irremediable conditions that cause enduring intolerable suffering).

Furthermore, we heard from health care provider organizations that, even without any legislation or regulation addressing the issue of conscientious objection, access to physician-assisted dying is likely not going to be a problem. We can draw a logical inference that a duty to inform and duty of non-abandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party) is, in their view, redundant.

We also heard repeatedly from groups representing individuals who want access to physician-assisted dying to be available that they believe that, without legislation establishing a duty to inform and a duty of non-abandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party), there may be problems with access. It is our hope that this approach will increase trust in the health care system among these individuals by setting out these duties in law. Health care providers will not be harmed by a redundant provision and members of the public who support access for physician-assisted dying will benefit. It therefore seems reasonable and prudent to enshrine the duties in legislation.

In developing the recommendations below, we have attempted to reconcile the patient's rights and freedoms (to conscience, autonomy, life, liberty and the security of the person) with the provider's (to conscience, religion/creed, and privacy). We have consulted extensively on these questions and have worked to create a system that ensures access without unnecessarily limiting the conscience rights of providers.

Duty to Inform

RECOMMENDATION 31: *Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs.*

All end-of-life options (including palliative care and physician-assisted dying) should be discussed with patients in a respectful way regardless of the provider's beliefs. Such requirements are often already included in professional codes of ethics. For example, the Canadian Medical Association's Code of Ethics requires that physicians provide patients with the information they need to make informed decisions about their medical care.

RECOMMENDATION 32: *Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner.*

Conscientiously objecting providers have a duty to inform new patients and, when appropriate, current patients of their position on physician-assisted dying. This allows patients to make an informed choice with respect to enrolling with or retaining that provider. Regulatory authorities and governments should produce educational materials for physicians and patients to help navigate these discussions. We also encourage all physicians to initiate and regularly revisit conversations with patients around advance care planning, the goals of care, and the patient's end-of-life wishes.

Duty to Care for the Patient

RECOMMENDATION 33: *Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4.*

To facilitate access to physician-assisted dying, conscientiously objecting health care providers must refer, transfer care or contact a third party in a timely manner and transfer records to another health

care provider or third party, as required. There is no expectation that they will assess the patient's eligibility for physician-assisted dying.

We heard from some stakeholders who believed that a referral in the context of physician-assisted dying implied that the conscientiously objecting physician had assessed the patient, found them eligible for physician-assisted dying and was transferring care for the purposes of providing the service. While this is an option available to those who object to the provision of service, we did not want to imply that assessment is an obligation, or that this was the only option available to providers.

When we discuss a direct transfer of care, we envisage a situation where a patient has requested physician-assisted dying and has already discussed end-of-life options with their health care provider. We recognize that some providers view a transfer of care as morally preferable to referral because, unlike referral, it is taken to neither explicitly nor implicitly affirm the service sought by the patient. A health care provider could transfer the patient to another health care provider for the assessment and treatment of the patient's medical condition and, if the patient meets the eligibility criteria, provision of physician-assisted dying. The receiving health care provider must be someone who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. Following the transfer of care, the receiving health care provider would follow the pathway outlined earlier in this report.

For those conscientiously objecting health care providers who are not willing to provide a direct transfer of care on conscience or religious grounds, we provide the option of contacting and transferring the patient's records through a publicly-funded system designed to ensure that patients are able to access a health care provider willing to accept them as a patient for assessment and, if the eligibility criteria are met, to provide physician-assisted dying. If this system is not in place, conscientiously objecting providers should be required to make a direct transfer of care to a health care provider who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. It is imperative that the burden of the transfer to another physician, institution or third party not fall on the patient seeking the care.

As described in Recommendation 4, we recommend a system where regional health authorities develop a publicly-funded care coordination system to help facilitate access to physician-assisted dying. One of this system's key functions should be to receive requests from unwilling or unable health care providers and transfer patients to providers who are willing and able to receive new patients.

Role of Institutions

Duties of Institutions

All institutions have certain responsibilities in common, many of which align with our recommendations related to physicians.

RECOMMENDATION 34: *All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.*

This recommendation will ensure that patients have clarity on what is permitted within the facility. They can then make informed decisions with respect to whether to enter or remain in the facility.

RECOMMENDATION 35: *Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.*

RECOMMENDATION 36: *Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.*

Taken together, the two recommendations above limit the power of institutions to restrict the autonomy of patients who may wish to seek physician-assisted dying at a later date, and providers, who may wish to provide physician-assisted dying outside a faith-based institution that does not offer physician-assisted dying. They represent an appropriate balance between patient and physician autonomy, patient access, and institutional autonomy.

Duties of Non Faith-Based Institutions

RECOMMENDATION 37: *Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.*

Governments have significantly more levers to influence the policies and practices of institutions that are funded in whole or in part by public funds. However, as a point of principle, we believe that physician-assisted dying should be available wherever people are living and dying. This includes privately-funded institutions. Recognizing that not all institutions will feel capable of providing physician-assisted dying for a variety of reasons, including size, geography and mandate, we concluded that institutions should be permitted to offer a patient transfer to another institution, as long as the receiving institution can and will provide a health care provider who is willing and able to accept the

person as a patient, to assess whether the criteria for access to physician-assisted dying have been met, and provide physician-assisted dying where the criteria for access have been met.

Duties of Faith-Based Institutions

RECOMMENDATION 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Faith-based institutions have a duty to care for and not abandon the patients within their institution. While they should not be required to provide access to physician-assisted dying, they must still ensure access for patients who wish to seek it.

When a patient makes a request for physician-assisted dying, faith-based institutions should be required to either allow for the assessment and provision of physician-assisted dying within the institution or make arrangements for an effective transfer of the patient to a non-objecting institution. This transfer must also include the transfer of all relevant records, and must be made to a non-objecting institution where the patient's medical condition can be assessed and treated by a health care provider who is willing and able to assess whether the patient meets the eligibility criteria for physician-assisted dying and, if so, can provide assistance. If a safe and timely transfer to a non-objecting institution is not possible, the objecting institution must allow an outside health care provider to assess the patient and, if the eligibility criteria for physician-assisted dying are met, to provide assistance. The receiving outside health care provider would follow the pathway for physician-assisted dying as outlined previously in this report.

Oversight

It is essential for a properly functioning regulatory framework that there is robust and independent oversight to: monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. To support the implementation of physician-assisted dying, we recommend two levels of oversight: one at the provincial/territorial level and one at the pan-Canadian level.

RECOMMENDATION 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

An independent review committee system should be established in each province and territory, or with agreement amongst groups of provinces and territories, to monitor compliance with the legal and regulatory framework for physician-assisted dying and to facilitate public reporting on physician-assisted dying in Canada. The Review Committees should include a physician, a legal expert, an ethicist, and a public representative who can determine whether the relevant laws and professional standards have been followed. Where issues arise, the Review Committees should report any potential violations to the appropriate authorities.

Individual cases should be reviewed after provision of assistance (see Recommendation 29). For each case of physician-assisted dying, the Review Committee will review the documentation submitted by physicians. As a starting point, we recommend that all cases be reviewed by the Review Committee. However, it may be possible for only a sample to be reviewed once the system of providing physician-assisted dying has matured in Canada. Where the Committee determines that the physician acted in compliance with the relevant laws and professional standards, the physician will be informed and the file will be closed. Where a physician is thought to have potentially violated laws or standards, the Review Committee will report this to the relevant professional regulatory authority for investigation and response under its professional self-regulatory powers. Any subsequent reporting by a regulatory authority to the police will follow the regulatory authority's normal processes with respect to reporting suspected violations of provincial or federal legislation. Where the Review Committee determines that a health institution or any other person was non-compliant with provincial/territorial legislation, it will refer the case to the relevant regulatory authority in its jurisdiction (e.g., regional health authority, Ministry of Health).

The Review Committee will also compile de-identified population-level data on physician-assisted dying in its jurisdiction. This may include incidence of physician-assisted dying, the underlying causes of death, the settings where physician-assisted dying was provided (e.g., hospital, home), the regulated health professional who provided the service (e.g., physician, nurse practitioner), the modality of physician-

assisted dying (i.e., self-administered or provider-administered), and any complications arising in the provision of physician-assisted dying. To facilitate pan-Canadian comparisons, common metrics should be developed for application across Review Committees.

The Review Committee should be required to prepare an annual report of its findings for the purpose of public reporting on physician-assisted dying at a provincial or territorial level and for submission to the pan-Canadian Commission on End-of-life Care.

RECOMMENDATION 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-life Care to provide system oversight and to report to the public.

A pan-Canadian Commission on End-of-Life Care should be established to report to the public on the implementation of physician-assisted dying. The Commission could be developed as part of a pan-Canadian strategy on palliative and end-of-life care, including physician-assisted dying, or it could be a separate body if a pan-Canadian strategy cannot be developed in a timely manner. It should report annually on things such as: the number of cases of physician-assisted dying; the number of requests for physician-assisted dying including those that were refused or never acted upon; and demographic data about who is requesting physician-assisted dying and why. These reports will help to ensure that the system in place is – and is seen to be – legitimate, trustworthy and non-discriminatory.

The Commission should also be given additional functions associated with a robust regulatory framework for physician-assisted dying including to:

- conduct or commission research it deems necessary in accordance with relevant federal, provincial, and territorial law and policy;
- consult with the public, health providers, and other experts on issues related to physician-assisted dying;
- inform the development and delivery of resources on moral, legal, and clinical aspects of physician-assisted dying to health care providers, legal professionals, and the public; and
- make recommendations to federal, provincial and territorial governments about potential law and policy reform with respect to physician-assisted dying in Canada.

Research and Continuing Quality Improvement

RECOMMENDATION 41: There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.

Physician-assisted dying is a new practice in Canada. We are entering a critical phase in which evidence-gathering should be undertaken systematically and rigorously to inform responses to these Canadian questions. Although other jurisdictions provide insight into its practice, physician-assisted dying in the Canadian context raises unique policy and practice questions. There are unanswered questions, for example, about organ donation in the context of physician-assisted dying and the role and regulation of palliative sedation. Answering these questions will require the research community and governments to work collaboratively to advance a coordinated research agenda in service of Canadians.

Health Professional Education and Training

RECOMMENDATION 42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.

A recurrent theme throughout our consultation with stakeholders was the need for education and training of health professionals with respect to physician-assisted dying, including its clinical, legal, and ethical aspects. Health professional education and training should include both undergraduate and post-graduate education, as well as continuing professional education of licensed health professionals. Health professional education should not be limited to regulated health professionals, but should also address the learning needs of other health care workers involved in patient care. Although some clinical specialties may be more likely to participate in the provision of physician-assisted dying, end-of-life conversations including about physician-assisted dying may arise in any therapeutic relationship between patients and providers. This suggests that physician-assisted dying and related end-of-life issues should be a core component of all health professional education. The curriculum should ideally include training on: how to talk with patients about physician-assisted dying; what the legal, regulatory, and ethical obligations are; the extent and limits of conscientious objection; the psychosocial aspects of illness; awareness of and sensitivity to cultural, linguistic, and other forms of diversity; and assessment of social vulnerability. Notably, this curriculum would be broadly relevant to the delivery of high quality end-of-life care and other clinical care.

Public Education and Engagement

RECOMMENDATION 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

Public education and engagement are critical to a transparent system of end-of-life care, including physician-assisted dying. There is a need for public education on what physician-assisted dying is (and what it is not), how it fits within a continuum of end-of-life services, how it can be accessed and under what conditions, and how physician-assisted dying is governed, administered, and monitored, including what safeguards are in place. Patients and families also need information about what supports and services are available for patients and their families at the end-of-life. While some of this information may be provided by physicians and other health professionals in conversation with their patients, such information should also be readily publicly available for patients and members of the public. There is also a need for patient and public engagement to inform the continuing development of high-quality end-of-life care and supportive care, and the implementation of physician-assisted dying. Current best practices in patient and public engagement should be proactively incorporated into provincial and territorial planning and the implementation of physician-assisted dying.

APPENDICES

Appendix 1 – Member Biographies

DR. JENNIFER GIBSON (CO-CHAIR)

Ontario

Director of the University of Toronto Joint Centre for Bioethics

Jennifer Gibson is Sun Life Financial Chair in Bioethics and Director of the University of Toronto Joint Centre for Bioethics, and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto. She holds a PhD in philosophy (bioethics and political theory). Her research focuses on ethical governance and performance of health organizations and systems. Gibson directs the World Health Organization Collaborating Centre for Bioethics at the University of Toronto and is also a member on the Executive Committee for the Global Institute for Psychosocial, Palliative, and End-of-Life Care, University of Toronto and Princess Margaret Cancer Centre. Jennifer has served on government and health sector advisory committees on public health emergencies, critical care triage, drug funding and supply, and the Ebola response in Ontario and internationally.

MAUREEN TAYLOR (CO-CHAIR)

Ontario

Physician Assistant in Infectious Diseases and Medical Journalist

Maureen Taylor is a Physician Assistant (PA) in Infectious Diseases at Toronto East General Hospital, and an Associate Clinical Professor in the Department of Family Medicine at McMaster University. Prior to her studies as a PA, Maureen was a broadcast journalist for 25 years, including seven years as the National Medical/Health Reporter for the Canadian Broadcasting Corporation. Maureen is a three time winner of the Canadian Medical Association/Canadian Nurses Association awards for excellence in health reporting.

Maureen was married to microbiologist and infectious disease expert Dr. Donald Low, who was diagnosed with an inoperable brain tumour in February 2013. He died seven months later. Since then, Maureen has publicly advocated for the right of terminally ill Canadians to choose an assisted death.

DR. DOUG COCHRANE

British Columbia

Patient Safety and Quality Officer for BC and Chair of the BC Patient Safety and Quality Council

Dr. Doug Cochrane is the Patient Safety and Quality Officer for BC and Chair of the BC Patient Safety and Quality Council. He is also a Professor at the University of British Columbia in Neurosurgery.

The BC Patient Safety & Quality Council has adopted a definition of quality that spans health care. Care at the end-of-life is one sector in which the Council advocates, supporting end-of-life planning, palliation where needed and primary care and home services.

Given the nature of Dr Cochrane's clinical practice as a neurosurgeon, meeting and care for and with families and patients facing end-of-life are common. Arising from this experience, Dr Cochrane recognizes the importance of how a disease process and treatments are affected by the context of the patient and family. Care is not only providing treatments of a disease process or the minimization of disability, but when applicable, allaying suffering and respecting patient family autonomy. He has written on the Groningen Protocol.

DR. JOCELYN DOWNIE

Nova Scotia

Professor in the Faculties of Law and Medicine at Dalhousie University

Jocelyn Downie is a Professor in the Faculties of Law and Medicine at Dalhousie University. She is a Fellow of the Pierre Elliott Trudeau Foundation as well as a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences. She received an honours BA and MA in Philosophy from Queen's University, an MLitt in Philosophy from the University of Cambridge, an LLB from the University of Toronto, and an LLM and Doctorate in Law from the University of Michigan. After graduation from law school, she clerked for (former) Chief Justice Antonio Lamer at the Supreme Court of Canada.

Specifically in the area of assisted death, Downie has published numerous books and articles including *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*, winner of the 2005 Abbyann Lynch Medal in Bioethics from the Royal Society of Canada. Downie was also a Special Advisor to the Senate of Canada Committee on Euthanasia and Assisted Suicide, a member on the Royal Society of Canada's Expert Panel on End-of-Life Decision Making, and a member of the pro bono legal team in *Carter*.

RUTH GOBA

Ontario

Human Rights Lawyer & Commissioner, Ontario Human Rights Commission

From February to October 2015, Ruth served as the Interim Chief Commissioner of the Ontario Human Rights Commission. She was first appointed as a Commissioner by the Government of Ontario in 2006 and continues in that capacity today.

Ruth received her B.A. (Honours) from the University of Toronto (1996) and her LLB from Osgoode Hall Law School (2000). She was called to the Bar in 2002.

After graduating from law school, Ruth worked in India for an international NGO on women's equality rights and with the United Nations Special Rapporteur on the Right to Adequate Housing. She has appeared before the UN Committee on Economic, Social and Cultural Rights in Geneva, Switzerland and has advocated at the UN Human Settlement Programme (UN HABITAT) in Nairobi, Kenya. In 2001, she completed her articles of clerkship at ARCH Disability Law Centre and then worked for the Centre for Equality Rights in Accommodation (CERA), a human rights organization that works domestically and internationally for equality in housing and for the realization of economic and social rights. From 2007 to 2009, she was the Executive Director of CERA. In private human rights law practice, Ruth's focus was on gender, disability and racial discrimination in employment and education.

Ruth has taught Disability Studies at Ryerson University, served on the Board of the National Association of Women in the Law and on LEAF's Legal Committee.

DR. NUALA KENNY

Nova Scotia

Professor Emeritus Dalhousie University Department of Bioethics

Dr. Nuala Patricia Kenny received her BA, Magna Cum Laude, from Mount Saint Vincent University in 1967, an MD from Dalhousie in 1972 and became a Fellow of the Royal College of Physician and Surgeons of Canada in Paediatrics in 1975. In 1993 she completed a Bioethics Fellowship at the Kennedy Institute of Ethics at Georgetown University.

After a distinguished career in pediatrics at the Hospital for Sick Children, Toronto and Queen's University, Kingston, she returned to Dalhousie as Professor and Head of the Department of Pediatrics and Chief of Pediatrics at the Izaak Walton Killam Hospital in 1988. In 1995, she became the founding Chair of the Department of Bioethics of the Dalhousie Faculty of Medicine.

From February to November 1999, Dr. Kenny was seconded as Deputy Minister of Health for the Province of Nova Scotia. From 2009-2014 she served as Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada.

Past President of both the Canadian Pediatric Society and the Canadian Bioethics Society and author of over one hundred and eighty papers and three books, Dr. Kenny was appointed an Officer of the Order of Canada for her contributions to child health and medical education in 1999. She has received the Lifetime Achievement Award of the Canadian Bioethics Society, the Distinguished Service Award from the Canadian Health Association, the Catholic Health Association of Canada's Performance Citation Award, the Canadian Medical Association's Marsden Ethics Award and the Dalhousie University Alumni Achievement Award.

She has received six Honorary Doctorates for her work in child health, medical education and bioethics from Mount Saint Vincent University, Halifax, the Atlantic School of Theology, Halifax, Regis College,

Toronto, St. Francis Xavier University Antigonish, The College of New Rochelle, New York and Saint Paul's University, Ottawa.

PROFESSOR ARTHUR SCHAFER

Manitoba

Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Arthur Schafer is Director of the Centre for Professional and Applied Ethics, at the University of Manitoba. He is also a Full Professor in the Department of Philosophy and an Ethics Consultant for the Department of Paediatrics and Child Health at the Health Sciences Centre in Winnipeg. For 10 years he was Head of the Section of Bio-Medical Ethics in the Faculty of Medicine of the University of Manitoba. He has also served as Visiting Scholar at Green College, Oxford.

Schafer has received a number of awards and honours. He is a Canadian Commonwealth Scholar, Honorary Woodrow Wilson Scholar, and a Canada Council Fellow. At the University of Manitoba he has received the Stanton Teaching Excellence Award, the Campbell Award for University Outreach, and the University Teaching Service Award for Teaching Excellence. He has published widely in the fields of moral, social, and political philosophy. He is author of *The Buck Stops Here: Reflections on moral responsibility, democratic accountability and military values*, and co-editor of *Ethics and Animal Experimentation*. He has published over 90 scholarly articles and book chapters, covering a wide range of topics, with a special focus on issues in professional and bio-medical ethics, business and environmental ethics. Schafer is National Research Associate of the Canadian Centre for Policy Alternatives, which has published two of his reports. He has made several hundred conference presentations in Canada and abroad, and has written dozens of newspaper articles for *The Globe and Mail*, *The Toronto Star*, *The Winnipeg Free Press*, *The Medical Post*, and *The Sunday Times (London)*.

DR. TREVOR THEMAN

Alberta

Registrar of the College of Physicians and Surgeons of Alberta

Dr. Trevor Theman is the Registrar of the College of Physicians and Surgeons of Alberta (CPSA), the regulatory body of the practice of medicine in Alberta. The CPSA provides direction to members on ethics and other issues such as physician-assisted dying. Dr. Theman is the former president of the Federation of Medical Regulatory Authorities of Canada (FMRAC). FMRAC is the national voice of the medical regulatory authorities in Canada.

DR. KARIMA VELJI

Ontario

President of the Canadian Nurses Association and Integrated Vice President, Mental Health Services, for London Health Science Centre and St. Joseph's Health Care London

Dr. Karima Velji is the 46th President of the Canadian Nurses Association. She is the integrated vice-president for mental health at London Health Sciences Centre and St. Joseph's Health Care. Most recently, Dr. Velji was the chief operating officer and chief nursing executive at Baycrest, a global leader in innovations on aging and brain health, and was vice-president of patient care and chief nursing executive at the Toronto Rehabilitation Institute, now a program in the University Health Network.

She has led the development of patient experience projects for the Ministry of Health and Long-Term Care and Local Health Integration Networks in Ontario. She has also led external reviews of several organizations including the Sunnybrook Health Sciences Centre, Bruyère Continuing Care and Schlegel Villages. In addition, she is board vice-chair with Accreditation Canada.

Dr. Velji has been a senior leader of palliative care services within her organizational leadership roles. She has clinical background as an oncology and palliative care nurse.

Appendix 2 – List of Stakeholders Consulted

Written Stakeholder Submissions Received

- ARCH Disability Law Centre
- Association for Reformed Political Action Canada
- Association of Registered Nurses of Newfoundland and Labrador
- BC Civil Liberties Association
- Canadian Association for Community Living
- Canadian Bar Association
- Canadian Civil Liberties Association
- Canadian Council of Registered Nurse Regulators
- Canadian Federation of Catholic Physicians' Societies
- Canadian HIV/AIDS Legal Network
- Canadian Hospice Palliative Care Association
- Canadian Medical Association
- Canadian Medical Protective Association (CMPA)
- Canadian Nurses Association
- Canadian Partnership Against Cancer
- Canadian Society of Hospital Pharmacists
- Canadian Society of Palliative Care Physicians
- Canadian Society of Respiratory Therapists
- Canadian Unitarian Council
- Canadian Working Group on HIV and Rehabilitation
- Catholic Civil Rights League
- Catholic Health Alliance of Canada
- Catholic Health Corporation of Manitoba
- Centre for Israel and Jewish Affairs
- Centres for Addiction and Mental Health
- Christian Legal Fellowship
- Citizens with Disabilities Ontario
- College of Family Physicians Canada
- College of Pharmacists of Manitoba
- College of Physicians and Surgeons of Manitoba
- College of Physicians and Surgeons of Ontario
- College of Registered Nurses of Manitoba
- College of Registered Nurses of Nova Scotia
- Council of Canadians with Disabilities
- Covenant Health
- Doctors NS
- Dying With Dignity
- Evangelical Fellowship of Canada
- Health Quality Council of Alberta
- HIV & AIDS Legal Clinic Ontario
- Hospice Palliative Care Ontario

- Human Rights Watch
- Manitoba Multi-faith Council
- Mental Health Commission of Canada
- National Association of Pharmacy Regulatory Authorities
- Northern Health Region
- NWT Medical Association
- Ontario Hospital Association
- Ontario Medical Association
- Palliative Manitoba
- Patients Canada
- PEI College of Physicians and Surgeons
- Physicians' Alliance against Euthanasia
- Protection of Conscience Project
- Public Prosecutions New Brunswick
- Qikiqtani Medical Association
- Saskatchewan Association of Social Workers (SASW)
- Winnipeg Regional Health Authority

In-Person/Teleconference Consultations

- Association of Faculties of Medicine of Canada
- BC Civil Liberties Association
- Canadian Association for Community Living
- Canadian Association of Retired Persons
- Canadian Cancer Society
- Canadian Civil Liberties Association
- Canadian Council of Registered Nurse Regulators
- Canadian Hospice Palliative Care Association
- Canadian Life and Health Insurance Association
- Canadian Medical Association
- Canadian Medical Protective Association
- Canadian Psychiatric Association
- Canadian Society of Palliative Care Physicians
- Council of Canadians with Disabilities
- Council of Pharmacy Registrars of Canada
- Covenant Health
- Dying With Dignity
- Ontario Hospital Association
- David Zussman, Jarislowsky Chair on Management in the Public Sector, University of Ottawa
- Dr. James Downar, palliative care physician
- Dr. Eric Wasylenko, palliative care physician
- Mr. David Wright, palliative care nurse
- Dr. Paul Henteleff, palliative care physician
- Dr. Gary Rodin, psychosocial oncology and palliative care physician

Appendix 3 – Recommendations That Should Be Implemented Through Provincial/Territorial Legislation

Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.

Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying.

Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

Recommendation 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).

Recommendation 18: "Grievous and irremediable medical condition" should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as "grievous and irremediable" should not be delineated in legislation or regulation.

Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met.

Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.

Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs. (**See Note Below*)

Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner. (**See Note Below*)

Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4. (**See Note Below*)

Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.

Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.

Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.

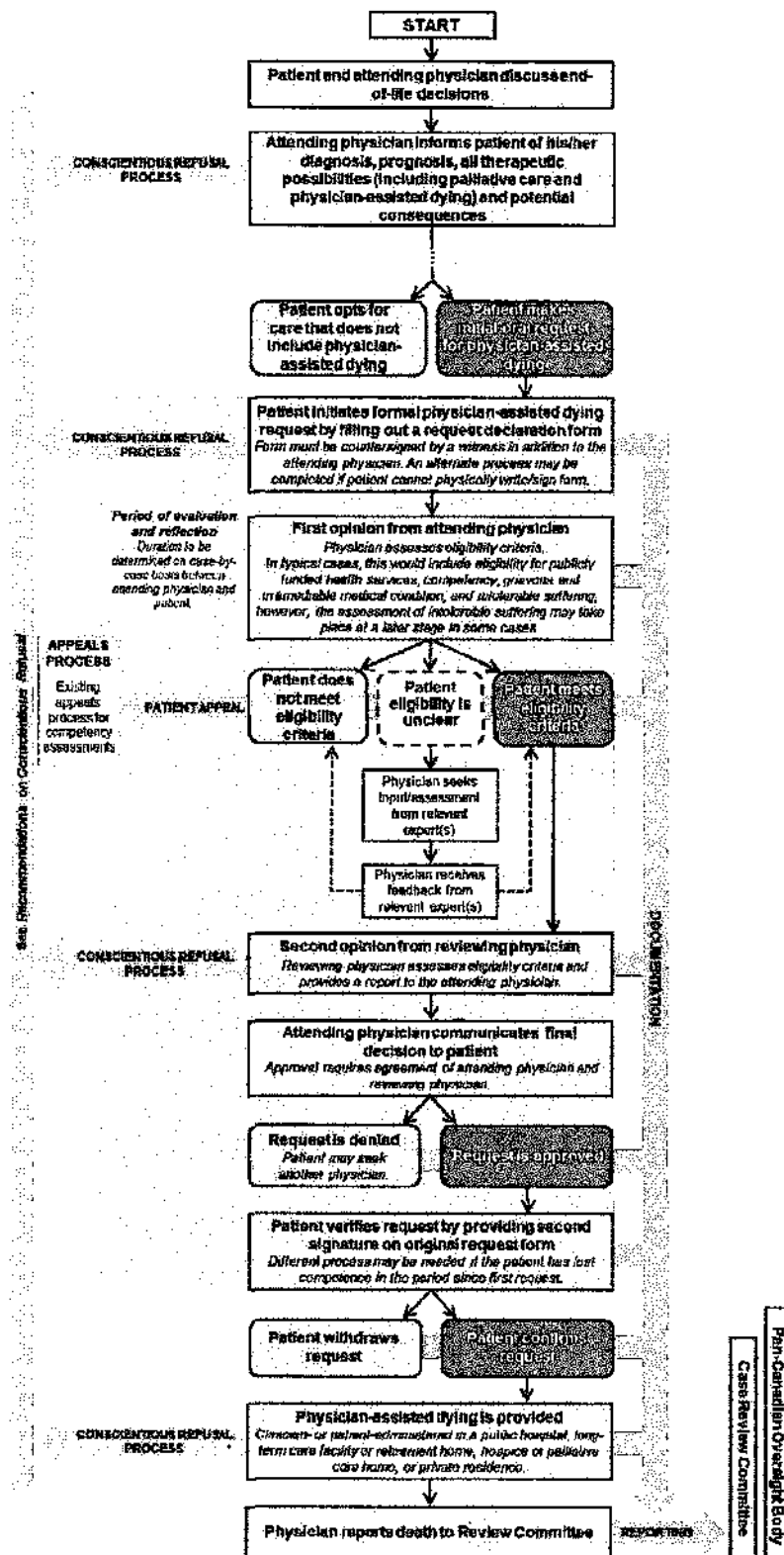
Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.

Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Recommendation 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

Note: All members of the Advisory Group agreed with the duties set out in these recommendations, but one member believes that they should be implemented through professional regulatory authority standards rather than legislation.

Appendix 4 – Patient Pathway



Cover art designed by Freepik

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 1044109

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

TITLE: Physician Assisted Dying – *Coroners Act* implications

PURPOSE: To discuss the BC *Coroners Act*, as it pertains to implementing Physician Assisted Dying.

BACKGROUND:

- On February 6, 2015, the Supreme Court of Canada struck down the *Criminal Code* prohibitions against physician assisted dying (Assisted Dying) on the basis that they violate the *Canadian Charter of Rights and Freedoms*.
- The Supreme Court ruling was stayed until February 2016, giving the federal, provincial and territorial governments one year to enact legislation or policies to clarify the rules and safeguards around Assisted Dying, should they choose to do so.
- On November 30, 2015, the P/T Expert Advisory Group on Physician Assisted Dying (the Advisory Group) issued its final report (the Final Report – Appendix A) with non-binding advice for P/T Ministers of Health and Justice on implementing Assisted Dying.
- On December 3, 2015, the Attorney General of Canada filed a motion for a six-month extension of the Supreme Court's decision on Assisted Dying. Subject to approval, the new deadline for implementation would be August 6, 2016.
- The BC *Coroners Act* received assent on May 31, 2007.

DISCUSSION:

- The Advisory Group's Final Report includes four recommendations that directly relate to the *Coroners Act* and/or have potential implications for the BC Coroners Service:
 - **Recommendation 4:** All provinces and territories should ensure access to Assisted Dying, including both physician-administered and self-administered Assisted Dying.
 - **Recommendation 29:** Following the provision of Assisted Dying, physicians should file a report with a Review Committee to support the review of each individual case.
 - **Recommendation 39:** Provincial and territorial governments should establish [...] Review Committee systems to review all cases of Assisted Dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards; transparency and accountability.
 - **Recommendation 30:** Assisted Dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for Assisted Dying should be listed as the cause of death.

Coroners' Reviews of Self-Administered Deaths/Suicides

- Section 2 of Part 2 of the *Coroners Act* includes a requirement that anyone with information that a person has died as a result of self-inflicted illness or injury must immediately report the facts and circumstances to a Coroner or a peace officer.
- Based on legal advice, this requirement would apply to the Assisted Death of a person as a result of taking medication prescribed by a physician.
- On receiving such a report, either directly or from a peace officer, a Coroner would be required by Section 7 of the *Coroners Act* to investigate the death.
- The aforementioned requirements to report and investigate could not be avoided or overwritten by means of policy.

Case Review

- The proposed Review Committee for Assisted Dying cases, as described in recommendations 29 and 39 from the Final Report (above), is primarily intended to ensure clinical criteria for Assisted Dying fall within reasonable limits and are not subject to abuse.
- In fulfilling this medical oversight and accountability role, the Review Committee would likely be performing some activities that overlap with BC Coroners Service duties already enshrined in legislation.
- To reduce duplication of effort and ensure role clarity, any Review Committee for Assisted Dying cases in BC should be developed in consultation with the BC Coroners Service.

ADVICE:

- The Chief Coroner should be involved as soon as possible in implementation planning for Assisted Dying to ensure all implications for the Coroners Service of the Supreme Court's decision are fully addressed.

Program ADM/Division:	Doug Hughes, ADM, Health Services Policy Division
Program Contact (for content):	Brian Sagar, Director of Patient Safety, 250-952-2753
Date:	December 22, 2015

Scheffel, Emile HLTH:EX

From: Docs Processing HLTH:EX
Sent: Tuesday, January 12, 2016 2:19 PM
To: Scheffel, Emile HLTH:EX
Cc: HLTH Ministers Office; Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: 1044109 - ProgGen IBN for MTL - Physician Assisted Dying Coroners Act Implications
Attachments: 1044109 - Appendix A - P T Expert Advisory Group PAD Final Report.pdf; 1044109 - IN Physician Assisted Dying Coroners Act Implications - 2015 Dec 21.doc

Importance: High

Hi Emile:

Program staff advised this material was not initially prepared for the discussion tomorrow, but it would likely be beneficial for the Minister to review prior to.

Thanks so much,

Kathy Simonson
Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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From: Scheffel, Emile HLTH:EX
Sent: Monday, January 11, 2016 8:00 AM
To: Docs Processing HLTH:EX; HLTH Ministers Office
Cc: Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: RE: 1044109 - ProgGen IBN for MTL - Physician Assisted Dying Coroners Act Implications

Was this intended for the JAG/PSSG/HLTH meeting on Wednesday?

Thanks E

From: Docs Processing HLTH:EX
Sent: Friday, January 8, 2016 2:22 PM
To: HLTH Ministers Office
Cc: Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: 1044109 - ProgGen IBN for MTL - Physician Assisted Dying Coroners Act Implications

Hi All:

The attached briefing document has been prepared by HSD for Minister's information regarding *BC Coroners Act*, as it pertains to implementing Physician Assisted Dying. This has been approved by Doug Hughes as ADM and A/Associate DM. A copy will be given to Lynn Stevenson upon her return. Anne Stearn has reviewed.

Please advise if a briefing is required

kathy.simonson@gov.bc.ca

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Page 0248 to/à Page 0290

Withheld pursuant to/removed as

s.13

Scheffel, Emile HLTH:EX

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:37 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Yup this is a problem.

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:36 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: TB - Jan 19

Hi there,

During capital briefing earlier, Manjit said the item is scheduled for 1-5 – just checking in as we have 9-1 booked in MTL's calendar, with other commitments in the afternoon.

Could you please confirm?

Thanks E

Scheffel, Emile HLTH:EX

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:24 PM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: s.13
s.13

Yes it is still on his iPad under DBN's for decision.

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:18 PM
To: Jukes, Shaina HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: s.13
s.13

Did it already go up to him?

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:17 PM
To: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: FW: s.13
s.13

The attached DBN is on MTL's iPad for approval, it is one staff feel is time sensitive. Derek and Emile if either of you get a moment can you please follow up with MTL on it.

Thank you,
Shaina

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Andrachuk, Andrea HLTH:EX
Sent: Friday, January 8, 2016 9:59 AM
To: Jukes, Shaina HLTH:EX
Subject: FW:s.13
s.13

From: Docs Processing HLTH:EX

Sent: Wednesday, December 16, 2015 9:25 AM

To: HLTH Ministers Office

Cc: Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX

Subject: s.13

s.13

Hi All:

The attached briefing document and power point presentation have been prepared by MBPSD for Minister's decision on PharmaCare coverage of the cholinesterase inhibitor drugs to complete the Alzheimer's Drug Therapy Initiative. Barbara Walman and Manjit Sidhu, ADMs and by Lynn Stevenson, Associate DM have approved. We understand that a briefing has been requested and Andrea will be in touch with your office to arrange.

We would appreciate receiving a copy of the signed document once Minister has approved.

Thanks so much,

Kathy Simonson

Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health

5-3 1515 Blanshard St, Victoria BC V8W 3C8

Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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Scheffel, Emile HLTH:EX

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:23 PM
To: Andrachuk, Andrea HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; McCormick, Erika HLTH:EX; Scheffel, Emile HLTH:EX
Subject: RE: Call for Presenters - 2016 BCCPA Annual Conference

Hmmmm I wonder why we didn't get it. Derek did you check with the PS?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 3:21 PM
To: Jukes, Shaina HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; McCormick, Erika HLTH:EX; Scheffel, Emile HLTH:EX
Subject: RE: Call for Presenters - 2016 BCCPA Annual Conference

Ok thanks, if the Minister or PS did want to present just noting the date for presentation proposals is January 15.
Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:12 PM
To: Andrachuk, Andrea HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: Call for Presenters - 2016 BCCPA Annual Conference

Hi Andrea, It looks like we don't have a record of receiving this in the MO.

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Andrachuk, Andrea HLTH:EX
Sent: Thursday, January 7, 2016 3:18 PM
To: Jukes, Shaina HLTH:EX

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: BC Care Providers Association [<mailto:jesse=bccare.ca@gmail2.com>] **On Behalf Of** BC Care Providers Association
Sent: Thursday, August 20, 2015 11:05 AM
To: Hughes, Doug J HLTH:EX
Subject: Call for Presenters - 2016 BCCPA Annual Conference

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**BC CARE PROVIDERS
ASSOCIATION**

Call for Presenters - 2016 BCCPA Annual Conference

The BC Care Providers Association is pleased to announce a Call for Presenters for our Annual Conference May 29-31, 2016, in Whistler, B.C.

There will be several streams of workshop topics including: Residential Care; Workplace Health and Safety; and a mixed option (including Home Care, Assisted Living and Faith-Based Care). The overall theme of this year's conference is ***Ensuring Excellence: Building a Stronger Continuing Care Sector.***



Our **2015 conference** was a great success with over 480 delegates attending the event including key healthcare experts such as former Premier of Prince Edward Island Robert Ghiz and Dr. Samir Sinha, Director of Geriatrics at Mount Sinai and the UHN hospital. This is a must-attend event for the continuing care sector and its stakeholders.

We invite you to submit an abstract of what you propose to share with conference attendees. Workshops are allotted 45-60 minutes for presentation times.

Presentations may take the form of a panel discussion or workshop. Other formats will also be considered. If possible, please outline how your presentation will attempt to interact with workshop attendees.

BCCPA and non-BCCPA members are eligible to submit a proposal.

For full submission requirements, please **click here**. The deadline for proposals is **January 15, 2016**.

Participants who respond on or before **Dec. 1, 2015** and are selected as a workshop speaker are eligible to a **15 per cent discount** on their delegate fees. Those who do not respond before the

Non-Member: \$950 (Early Bird: \$850)
Government/Health Authority: \$375
BCCPA Associate Member: \$375
Non-exhibiting Commercial Delegate: \$1,400
Student Rate (F/T post-secondary): \$200 per day
Spousal Sunday Evening Reception: \$50
Spousal Monday Evening Dinner: \$75

****NOTE: Speakers must register for the conference at their own expense.****

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BC Care Providers Association
738-4710 Kingsway
Burnaby, BC V5H 4M2
604.736.4233

Scheffel, Emile HLTH:EX

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:23 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: FPT sidebar re e-cigarettes

Ok

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:22 PM
To: Jukes, Shaina HLTH:EX
Subject: RE: FPT sidebar re e-cigarettes

We're going to try and do it right after the p/t press conference so IGR will work it into the schedule

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:21 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: FPT sidebar re e-cigarettes

Did anything ever come of this?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Scheffel, Emile HLTH:EX
Sent: Friday, January 8, 2016 2:22 PM
To: Marr, Ann HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Merrifield, Katy PREM:EX; Jukes, Shaina HLTH:EX
Subject: FPT sidebar re e-cigarettes

This has come in now – do we figure we can accommodate?

Thanks E

From: Lake, Terry HLTH:EX
Sent: Friday, January 8, 2016 2:07 PM
To: Scheffel, Emile HLTH:EX

Begin forwarded message:

From: "Afrah, Kadijo (MOHLTC)" <Kadijo.Afrah@ontario.ca>
Date: January 8, 2016 at 2:03:13 PM PST
To: "Terry.Lake@gov.bc.ca" <Terry.Lake@gov.bc.ca>
Subject: This message is being sent on behalf of Ontario Associate Minister of Health Dipika Damerla

Dear Minister,

I look forward to seeing you in Vancouver in a few weeks. The Federal/Provincial/Territorial Health Ministers' Meeting is shaping up to be a great discussion of our shared priorities and concerns.

On that note, I was hoping that we might be able to dedicate some time to specifically discussion the e-cigarette issues. As you may be aware, we are on the cusp of implementing some new legislation and I would be most interested in hearing how similar work has gone in your jurisdiction. If you are interested and available I might suggest we gather at about 3:30 on Wednesday the 20th for a half hour or so. If that time doesn't work for you perhaps you could identify another opportunity.

Please feel free to reply to Kadijo, and we will determine an appropriate location closer to the meeting.

Kind Regards,

Dipika Damela
Associate Minister of Health and Long Term Care
(Long Term Care and Wellness)

Kadijo Afrah
Scheduler and Office Manager
Office of the Hon Dipika Damerla
Associate Minister of Health and Long Term Care (Long Term Care and Wellness)

11th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
Tel: 416-212-3180
Fax: 416 326 1571

Scheffel, Emile HLTH:EX

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 3:21 PM
To: Jukes, Shaina HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; McCormick, Erika HLTH:EX; Scheffel, Emile HLTH:EX
Subject: RE: Call for Presenters - 2016 BCCPA Annual Conference

Ok thanks, if the Minister or PS did want to present just noting the date for presentation proposals is January 15.
Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:12 PM
To: Andrachuk, Andrea HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: Call for Presenters - 2016 BCCPA Annual Conference

Hi Andrea, It looks like we don't have a record of receiving this in the MO.

Shaina Jukes

Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca

From: Andrachuk, Andrea HLTH:EX
Sent: Thursday, January 7, 2016 3:18 PM
To: Jukes, Shaina HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; McCormick, Erika HLTH:EX
Subject: Call for Presenters - 2016 BCCPA Annual Conference

Hi Shaina et al,

Can you please advise if Minister Lake or the Parliamentary Secretary are scheduled to present at this conference in May?

Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: BC Care Providers Association [<mailto:jesse=bccare.ca@cmail2.com>] **On Behalf Of** BC Care Providers Association
Sent: Thursday, August 20, 2015 11:05 AM



Call for Presenters - 2016 BCCPA Annual Conference

The BC Care Providers Association is pleased to announce a Call for Presenters for our Annual Conference May 29-31, 2016, in Whistler, B.C.

There will be several streams of workshop topics including: Residential Care; Workplace Health and Safety; and a mixed option (including Home Care, Assisted Living and Faith-Based Care). The overall theme of this year's conference is ***Ensuring Excellence: Building a Stronger Continuing Care Sector.***



Our **2015 conference** was a great success with over 480 delegates attending the event including key healthcare experts such as former Premier of Prince Edward Island Robert Ghiz and Dr. Samir Sinha, Director of Geriatrics at Mount Sinai and the UHN hospital. This is a must-attend event for the continuing care sector and its stakeholders.

We invite you to submit an abstract of what you propose to share with conference attendees. Workshops are allotted 45-60 minutes for presentation times.

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BCCPA and non-BCCPA members are eligible to submit a proposal.

For full submission requirements, please [click here](#). The deadline for proposals is **January 15, 2016**.

Participants who respond on or before **Dec. 1, 2015** and are selected as a workshop speaker are eligible to a **15 per cent discount** on their delegate fees. Those who do not respond before the early-bird deadline will pay full price.

We look forward to receiving your proposal!

Fees:

Member: \$650 (Early Bird: \$550)

Non-Member: \$950 (Early Bird: \$850)

Government/Health Authority: \$375

BCCPA Associate Member: \$375

Non-exhibiting Commercial Delegate: \$1,400

Student Rate (F/T post-secondary): \$200 per day

Spousal Sunday Evening Reception: \$50

Spousal Monday Evening Dinner: \$75

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BC Care Providers Association

738-4710 Kingsway

Burnaby, BC V5H 4M2

604.736.4233

CORE MESSAGING

Updated: January 2016

Ministry of Health

B.C. HEALTH ACCOMPLISHMENTS

- **B.C. has one of the best overall health systems in Canada:** British Columbia was rated number one in Canada for health care according to data released by the Organization for Economic Co-operation and Development in June 2014. B.C. was also the only province to receive an overall “A” grade for health status in a report from the Conference Board of Canada, released May 2013.
- **B.C. has one of the best overall cancer survival rates in Canada:** According to the 2015 Canadian Cancer Society's Canadian Cancer Statistics report, B.C. maintains one of the lowest overall cancer incidence and mortality rates in Canada. Our lung, kidney and colorectal cancer incidence rates are the lowest in the country.
- **Longest life expectancy in Canada:** Life expectancy in British Columbia is the highest in Canada at 82.65 years in 2013.
- **Thousands more surgeries:** Between 2000/01 and 2014/15, we have increased the annual number of knee replacements from 2,922 to 7,366 (152 per cent), hip replacements from 2,892 to 5,583 (93 per cent), and cataract surgeries from 31,215 to 51,774 (66 per cent). We've also increased the annual number of angioplasties (heart procedure) from 4,427 to 7,343 (66 per cent). The total number of surgeries received by British Columbians in 2014/15 was 553,811 – over half of which were never placed on a waiting list.
- **Best HIV/AIDS care in the country:** British Columbia is recognized as a global leader in the fight against HIV/AIDS due to the innovative programs that have expanded access to medications and treatments. Since 1996, HIV/AIDS-related deaths have decreased by 80 per cent thanks in large part to programs like Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS) and Treatment as Prevention.

- **Thousands more doctors and nurses:** Government has more than doubled medical school seats, adding 160 undergraduate first-year seats since 2003. B.C. now graduates 288 medical students a year. We've increased the number of practicing nurses to more than 50,000 and have added over 4,500 new nursing education spaces – more than double the number in 2001.
- **Lowest smoking rate in Canada:** Tobacco use is the single most preventable cause of disease and death in British Columbia. B.C. has the lowest smoking rate in Canada at about 15.3 per cent. While there are still over half a million British Columbians who smoke, since September 2011, 187,000 people have accessed B.C.'s Smoking Cessation program.
- **B.C. has the lowest heart attack rate in Canada:** A 2013 report from the Canadian Institute for Health Information confirms that British Columbia has the lowest overall heart attack rate per capita in Canada and leads the country in several other health indicators. The report estimates if all provinces had the same heart attack rate as B.C.; there would be a decline of 19.5 per cent in the national heart attack rate.
- **Building better patient care:** Approximately \$10 billion has been invested in health capital since 2001 (as of March 2015). This includes new hospitals, emergency departments and seniors' facilities throughout the province including Abbotsford, Vancouver, Victoria, Fort St. John, Surrey, Prince George, Nanaimo and Haida Gwaii.



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Scheffel, Emile HLTH:EX

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:56 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: TB - Jan 19

So would he be seeking leave between 1:30-3:30?

Am thinking maybe we could see if we could be 1st up at 1 or up at 3:30/4?

Jennifer Michell

Manager, Corporate Services

Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM
To: Michell, Jennifer HLTH:EX; Jukes, Shaina HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

He's tied up 2-3 pm, not including travel time.

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Emile,

If we can get on first on the agenda would that help? Is there a particular time he is available between 1-5 that we could work with TBS on?

Jennifer Michell

Manager, Corporate Services

Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:44 PM
To: Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

FYI Jen and Andrea – Shaina is submitting a leave request from TB which is indeed now from 1 to 5.

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:37 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:36 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: TB - Jan 19

Hi there,

During capital briefing earlier, Manjit said the item is scheduled for 1-5 – just checking in as we have 9-1 booked in MTL's calendar, with other commitments in the afternoon.

Could you please confirm?

Thanks E

Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM
To: Heinze, Laura R GCPE:EX
Cc: Scheffel, Emile HLTH:EX
Subject: IN

Hey Laura,

Can we get the latest IN we have on St. Pauls.

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 3:45 PM
To: Scheffel, Emile HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: Re: PAD - Coroners Act Implications

Thanks.

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:35 PM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: PAD - Coroners Act Implications

Minister,

Sorry for the late notice – staff have provided the attached (very brief) IN that you may want to take a look at for tomorrow's JAG/PSSG joint meeting.

It's on your iPad for tomorrow.

Thanks E

Scheffel, Emile HLTH:EX

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:44 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Hi Emile

Yes, I've just confirmed that with TBS myself, and this is the first that I was aware of the different time.

Jennifer Michell

Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:44 PM
To: Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

FYI Jen and Andrea – Shaina is submitting a leave request from TB which is indeed now from 1 to 5.

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:37 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Yup this is a problem.

Shaina Jukes

Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:36 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: TB - Jan 19

Hi there,

During capital briefing earlier, Manjit said the item is scheduled for 1-5 – just checking in as we have 9-1 booked in MTL's calendar, with other commitments in the afternoon.

Scheffel, Emile HLTH:EX

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 4:04 PM
To: Scheffel, Emile HLTH:EX
Subject: Re: TB - Jan 19

Yes I have sent this to Manjit to connect with TBS. Will keep posted.

Sent from my BlackBerry 10 smartphone on the Rogers network.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 4:02 PM
To: Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: TB - Jan 19

Jen, could you ask them about 3:30?

Thanks again...

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:58 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: TB - Jan 19

Thanks so much Emile

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

Warning: This email is intended only for the use of the individual or organization to whom it is addressed. It may contain information that is privileged or confidential. Any distribution, disclosure, copying, or other use by anyone else is strictly prohibited. If you have received this in error, please telephone or e-mail the sender immediately and delete the message.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:57 PM
To: Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: Re: TB - Jan 19

Sounds good -- will leave this with Shaina to work out.

Thanks! E

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:56 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: TB - Jan 19

So would he be seeking leave between 1:30-3:30?

Am thinking maybe we could see if we could be 1st up at 1 or up at 3:30/4?

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM
To: Michell, Jennifer HLTH:EX; Jukes, Shaina HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

He's tied up 2-3 pm, not including travel time.

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Emile,

If we can get on first on the agenda would that help? Is there a particular time he is available between 1-5 that we could work with TBS on?

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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Sent: Tuesday, January 12, 2016 3:44 PM
To: Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

FYI Jen and Andrea – Shaina is submitting a leave request from TB which is indeed now from 1 to 5.

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:37 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Yup this is a problem.

Shaina Jukes

Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:36 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: TB - Jan 19

Hi there,

During capital briefing earlier, Manjit said the item is scheduled for 1-5 – just checking in as we have 9-1 booked in MTL's calendar, with other commitments in the afternoon.

Could you please confirm?

Scheffel, Emile HLTH:EX

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:58 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: TB - Jan 19

Thanks so much Emile

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

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Could you please confirm?

Thanks E

Chris Halyk
President

19 Green Belt Drive
 Toronto, ON M3C 1L9
 1.800.387.8781 toll free 416.382.4888 tel
 416.382.4889 fax

www.janssen.ca

January 6, 2016

CH-Gen-126

Hon. Terry Lake
 Minister of Health
 PO Box 9050, Stn Prov Govt
 Victoria, BC
 V8W 9E2

Dear Minister Lake,

At Janssen Inc. (Janssen), we are dedicated to addressing some of the most important unmet medical needs of our time in oncology, immunology, neuroscience, infectious diseases, vaccines, and metabolic and chronic diseases. Driven by our commitment to patients, we bring innovative products, services and solutions to people throughout the world. Janssen is committed to not only ensuring the safety, efficacy, and value of our current products, but also to investing in early research to bring innovative new therapies to market. This commitment is demonstrated by our significant investments and partnerships with various research institutes across Canada, which involved over \$1 billion in 2015 alone.

Janssen is also committed to addressing health care policy issues that impact the lives of Canadians. In advance of your upcoming meetings in Vancouver with provincial and territorial Health Ministers, I would like to raise some key points in relation to national pharmacare.

Over the last year, there has been extensive public interest and discussion surrounding the concept of national pharmacare. At Janssen, we are supportive of policy initiatives that improve access to necessary medicines for patients. We also believe that patients should have equitable access to and choice in medicines, regardless of where they live across Canada. In October, Janssen hosted a national pharmacare round table event. The goal of this event was to provide a platform for a broad and diverse dialogue on national pharmacare. Although many individuals and stakeholder groups have voiced opinions on national pharmacare, at the time these diverse voices had not discussed the issue in a round table format. Participants included: academics; patient associations; professional associations; private insurers; think tanks; government; and industry.

Key discussion points included:

- Policy initiatives should focus on the gaps in the system (ie. patients who lack the means to pay for their medicines) versus focusing on populations who are already well served in the current system.
- Maintaining adequate access to drugs for all Canadians will be extremely challenging if it is going to be achieved within the confines of current drug budgets.
- An incremental policy approach should be adopted versus significant system reform. It was agreed that the systems currently in place should be leveraged and improved upon versus adding additional layers.
- Although many challenges in the system were discussed throughout the conversation (ie. inequities across drugs plans, access for low-income populations, overprescribing of medicines in the elderly), the group did not reach consensus on the key issues that should be prioritized due to the complex nature of the challenges. Janssen's position is that patient access to medicines is the most critical issue that needs to be addressed.

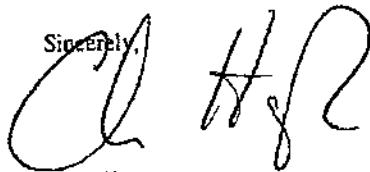
Contd...2/-

Janssen is supportive of policies that allow for the right medicine to get to the right patient in a timely and cost-effective manner, and we support efforts to manage overall healthcare costs more effectively. However, we believe that any price-focused strategy that restricts patient access to a narrow range of therapeutic options has the potential to have a negative impact on health outcomes – resulting in unanticipated costs in other parts of the health system. Cost-containment policies that target innovative medicines have a negligible short-term impact on the overall provincial health budget, can result in less than optimal outcomes for patients, and have a detrimental impact on the overall provincial government budget and on the attractiveness of Canada as an investment destination for research and development.

We encourage continued dialogue on a national approach to ensuring all Canadians have access to the medicines that they need, and feel that all stakeholders should collaborate in driving toward solutions. Janssen will continue to be an industry leader in advancing the dialogue, and would welcome the opportunity to directly collaborate with federal, provincial, and territorial governments as you deliberate on potential solutions.

Janssen remains a committed partner in ensuring public sector value in the procurement and utilization of innovative medicines, as well as optimal outcomes for patients. We would welcome the opportunity to discuss this letter with you or your staff at your convenience. Derek Badger, Janssen's Government Affairs and Market Access Manager for BC, will be reaching out shortly to find a mutually convenient time. Thank you for your consideration as you prepare for your important deliberations in Vancouver.

Sincerely,

A handwritten signature in black ink, appearing to read 'CH' or 'HCR', written over the word 'Sincerely,'.

Chris Halyk
President

Scheffel, Emile HLTH:EX

From: Badger, Derek (JOICA) <dbadger@its.jnj.com>
Sent: Tuesday, January 12, 2016 4:09 PM
To: Merrifield, Katy PREM:EX; Scheffel, Emile HLTH:EX
Subject: Janssen (J&J) Letter to Minister Lake
Attachments: Janssen Letter to Minister Lake - January 6, 2016.pdf

Hi Katy and Emile,

Happy New Year – I hope you are both doing well.

As an FYI, I just wanted to share a letter that has been sent from my President to Minister Lake, sharing our position on National Pharmacare in advance of next week's Health FPT meetings in Vancouver. Let me know if you have any questions or concerns – happy to discuss at your convenience.

Will either of you be attending the Health FPT meetings next week? I will be in Vancouver and would love the opportunity to briefly bring you up-to-speed on the status of our 'Biologics Portfolio Proposal' that we discussed back in October. Let me know if that might work – if not, perhaps we can find a few minutes over the phone sometime soon.

Thanks so much,

Derek Badger
Manager, Government Affairs and Policy
Office: 250.770.1600
Mobile: 250.486.0194



Scheffel, Emile HLTH:EX

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 4:11 PM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: FW^{s.13}
Attachments: s.13

Good afternoon Minister, I am following up on the attached Decision Briefing Document currently on your iPad. Please let me know if you have any further questions or would like a briefing on the topic. Alternatively please advise if it is approved for e-sig or if Derek can print it off for signing.

Thank you,
Shaina

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: McCormick, Erika HLTH:EX
Sent: Wednesday, December 16, 2015 4:41 PM
To: Lake, Terry HLTH:EX
Subject: s.13

Hi Minister,

The attached have been added to the iPad. Below is the path:

Approval → Briefing Notes for Decision → PharmaCare Coverage Decisions for Cholinesterase Inhibitor Drugs

Thank you!

Erika McCormick,
Administrative Assistant to the Honourable Terry Lake
Minister of Health
Email: Hlth.minister@gov.bc.ca / Phone: 2509533547
PO Box 9050 Stn Prov Govt Victoria BC V8W 9E2

Scheffel, Emile HLTH:EX

From: Badger, Derek [JOICA] <dbadger@its.jnj.com>
Sent: Tuesday, January 12, 2016 4:20 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks Emile, that would be great if you could connect me with the new CoS and MA when they are in place.

Do you know when they might be in place? Anyone I might already know from another Minister's office?

Appreciate your help with this.

Derek

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:16 PM
To: Badger, Derek [JOICA]; Merrifield, Katy PREM:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks for this, Derek. Happy new year to you, too.

Katy has moved on to a new role in the Premier's Office, and I will be transitioning out as well at the end of the month.

If I may, I will connect you with the new chief of staff once they are appointed to continue this conversation.

Best,

E

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jnj.com>]
Sent: Tuesday, January 12, 2016 4:09 PM
To: Merrifield, Katy PREM:EX; Scheffel, Emile HLTH:EX
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Hi Katy and Emile,

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Will either of you be attending the Health FPT meetings next week? I will be in Vancouver and would love the opportunity to briefly bring you up-to-speed on the status of our 'Biologics Portfolio Proposal' that we discussed back in October. Let me know if that might work – if not, perhaps we can find a few minutes over the phone sometime soon.

Thanks so much,

Derek Badger
Manager, Government Affairs and Policy
Office: 250.770.1600
Mobile: 250.486.0194

Scheffel, Emile HLTH:EX

From: Mills, Shane <Shane.Mills@leg.bc.ca>
Sent: Tuesday, January 12, 2016 4:30 PM
Subject: Morning Meeting

Hi all

Tomorrow's meeting will now be at 9 am.

Thanks
Shane

Sent from my BlackBerry 10 smartphone on the TELUS network.

Scheffel, Emile HLTH:EX

From: Badger, Derek [JOICA] <dbadger@its.jnj.com>
Sent: Tuesday, January 12, 2016 4:48 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

OK, thanks.

Do you know who from your office will be accompanying the Minister at the FPT meetings next week?

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Badger, Derek [JOICA]
Subject: RE: Janssen (J&J) Letter to Minister Lake

I would love to know! No intel just yet.

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jnj.com>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

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Do you know when they might be in place? Anyone I might already know from another Minister's office?

Appreciate your help with this.

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To: Badger, Derek [JOICA]; Merrifield, Katy PREM:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks for this, Derek. Happy new year to you, too.

s.22

If I may, I will connect you with the new chief of staff once they are appointed to continue this conversation.

Best,

E

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jnj.com>]
Sent: Tuesday, January 12, 2016 4:09 PM
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Hi Katy and Emile,

Happy New Year — I hope you are both doing well

Thanks so much,

Derek Badger

Manager, Government Affairs and Policy

Office: 250.770.1600

Mobile: 250.486.0194



**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 1045663

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

TITLE: Launch of Carrot Rewards

PURPOSE: To support a public launch of the Carrot Rewards national healthy living platform.

BACKGROUND:

The Ministry of Health (the Ministry), in partnership with the Public Health Agency of Canada (PHAC) and Social Change Rewards (SCR), is preparing to support the official launch of the innovative healthy living platform called Carrot Rewards. The partners are poised to have all elements in place to enable a public launch of Carrot Rewards in early 2016. The preferred approach is to have the Minister of Health participate in a public event or announcement of the release of Carrot Rewards, pending his interest and availability for the proposed timeframe.

Carrot Rewards will be available exclusively to British Columbians for a period of three months from date of launch. Confirmed points providers for the launch include SCENE, Aeroplan, Overwaitea, and Petro Points. SCR continues to negotiate with other potential point providers and the roster for that will continue to be of interest to the Ministry as the app grows in usage.

The Ministry, PHAC and SCR are working together to ensure that all elements are in place for a secure and successful launch. A central component of marketing Carrot Rewards will be through the opt-in databases that the point providers have, connecting to upwards of 850,000 British Columbian email addresses. The email promotion from each point provider will offer an incentive from their loyalty program for downloading the app. That email will also recognize the government partners and the national NGO partners (YMCA Canada, Heart & Stroke Foundation and the Canadian Diabetes Association). Extensive forecast modeling is in place to monitor engagement of this first invitation to British Columbians.

In preparation for the launch, SCR has hired a third-party privacy consultant to review privacy practices. This builds off the guidance provided by the Ministry's Health Information Privacy, Security and Legislation Branch which has concluded a Privacy Impact Assessment (PIA), signed off by the Office of the Information and Privacy Commissioner of BC.. A final revision of the privacy statement and supporting policy will be submitted with the PIA to the respective governments and the BC Healthy Living Alliance, in its role to support the Ministry's interests on this project.

SCR is responsible for providing technical support and will soft-launch to test technical issues prior to an announcement. An app demo will be made available to share with the Minister in advance of the announcement. The evaluation framework is being finalized and is led by PHAC and SCR, with the Ministry and the BC Healthy Living Alliance (BCHLA) participating in the process. Dr. Guy Faulkner, who holds a research chair

position with UBC in Applied Public Health, will provide an impartial evaluation to the framework. Evaluation of the project includes short, medium and long term measures, based on behavioural insights theory. SCR will be providing ongoing reporting to the BCHLA and the Ministry of the performance to guide the roll-out of content and demonstrate in-app activity and associated metrics.

Carrot Rewards is the result of a collaborative effort between PHAC, the Ministry (through partnership funding to the BCHLA) and Social Change Rewards along with its national, Non-Government Organizations (NGO) partners (YMCA Canada, Heart & Stroke Foundation and Canadian Diabetes Association). Having the BC Healthy Living Alliance on board complements the national NGO supporters and ensures we are addressing shared priorities toward reducing chronic disease and improved health outcomes.

DISCUSSION:

s.13

OPTIONS:

1. Support a proposed joint event with PHAC, the Ministry, BCHLA, SCR and NGO partners at the end of January 2016, to generate media and engagement opportunities.

s.13

FINANCIAL IMPLICATIONS:

Carrot Rewards is cost-shared by a \$5 million contribution from PHAC to Social Change Rewards and a \$2.5 million contribution by the Ministry, through a partnership with the BC Healthy Living Alliance. The program will reach a potential overall investment of \$12.5 million through in-kind contributions of up to \$5 million by Social Change Rewards. The investment from all parties is over a period of up to five years and is based on a pay-for-performance model.

RECOMMENDATION:

Option 1: Support the launch of Carrot Rewards and consider an opportunity for a joint event in late January 2016.

Approved/Not Approved
Terry Lake
Minister

Date Signed

Program ADM/Division: Population Health Surveillance and Public Health Planning, PPH
Telephone: 250-952-1467
Program Contact (for content): Regan Hansen, Director Health Engagement Unit
Drafter: Ashley Walden, Senior Manager Health Engagement Unit
Date: updated December 29, 2016

REQUEST FOR ATTENDANCE

PREPARED FOR: Minister Terry Lake

TOPIC: Request for Minister Lake's attendance and introductory remarks at the 2016 New Horizons in Responsible Gambling conference in Vancouver, February 1-3, 2016

TODAY'S DATE: January 4, 2016

BACKGROUND:

On February 1-3, 2016, BCLC will host the fourth annual New Horizons in Responsible Gambling Conference <http://horizonsrg.bclc.com/>

The three-day event builds off the successful of previous conferences, bringing together industry and community leaders in responsible gambling research and policy to exchange ideas, share information and learn best practices.

Conference attendance is made up of researchers, academics, treatment/prevention workers, media and public, and draws an average of 250 attendees.

The conference helps to position BCLC as a global leader in responsible gambling through encouragement for new learning and understanding of responsible gambling opportunities.

The conference demonstrates BCLC's corporate commitment to raising the bar in responsible gambling while providing a forum to showcase specific BCLC and GameSense initiatives.

New Horizons in Responsible Gambling Conference:

Location: Vancouver Convention Centre East
February 1-3, 2016

Schedule: <http://horizonsrg.bclc.com/about-the-conference/speakers-presenters-2016/overview.html>

Speaking Opportunity:

Minister Lake is invited to make opening remarks and introduce keynote speaker Dr. Carl Hart at the conference*.

Wednesday, February 3, 2016

9:00AM

Ballroom B

Keynote Address

Dr. Carl Hart, a neuropsychopharmacologist at Columbia University, will be presenting the keynote address on what we have learned from drugs and addiction and how we can apply those lessons to gambling. Drugs face many of the same stigma, policy, and access issues as gambling, and as such provide our industry with lessons already learned in improving social welfare. As a noted neuropsychopharmacologist, Dr. Hart will share his experience and knowledge on how the scientific and drug treatment communities have been complicit in propagating less than accurate drug-related information, which has contributed to bad drug policies and put many drug users at unnecessary risk. He will also explain how we can rectify this situation.

*Alternately, Minister Lake could introduce the UBC panel during the afternoon session (note: Minister de Jong has been offered this same speaking opportunity and will be given first preference). Dr. Luke Clark will be presenting the latest research from the Centre for Responsible Gambling Research at UBC.

From: Barker, Debbie HLTH:EX
Sent: Tuesday, December 22, 2015 2:56 PM
To: Emerson, Barb JAG:EX
Subject: RE: Resident Awareness Week Proclamation

Hi Barb,

The Ministry of Health would be pleased to consider a proclamation request for Resident Awareness Week, February 15, 2016 to February 19, 2016.

I will be in touch once I have received the appropriate Ministry approvals.

Thanks ☺

Debbie

Debbie Barker, Legislative Assistant, Legislation & Intergovernmental Relations, Partners and Innovation Division, Ministry of Health, PO Box 9637 Stn Prov Govt, Victoria BC V8W 9P1
Phone: 250-952-1622
Please consider the environment before printing this e-mail

From: Emerson, Barb JAG:EX
Sent: Tuesday, December 15, 2015 10:21 AM
To: Barker, Debbie HLTH:EX
Subject: FW: Resident Awareness Week Proclamation

Good morning, Deb.

Is your ministry willing to support this request?

Thanks very much.

Barb

Barbara Emerson | Manager
OIC Administration Office | Ministry of Justice
PO Box 9280 Stn Prov Gov't | Victoria, BC V8W 9J7
☎ 250 387-0725
♻ Please consider the environment before printing this e-mail or its attachments

From: Michelle Seymour [<mailto:michelle@residentdoctorsbc.ca>]
Sent: Friday, December 11, 2015 8:05 AM
To: Emerson, Barb JAG:EX
Subject: Resident Awareness Week Proclamation

Good Afternoon Mrs. Emerson,

Please see the attached document for our proposed proclamation for Resident Awareness Week, as in previous years.

Thank you so much,

Michelle Seymour
Project Administrator

**RESIDENT
DOCTORS**
OF BC

2399 - 650 West Georgia Street Vancouver, BC V6E 4N8

P: (604) 876-7636 F: (604) 873 7690 TF: 1-888-877-2722

residentdoctorsbc.ca

****Please note mhandysides@par-bc.org is no longer in use please update your address book to michelle@residentdoctorsbc.ca****

WHEREAS over 1300 resident physicians work throughout British Columbia providing round the clock health care to patients in clinics and hospitals, and

WHEREAS residents are a diverse group of medical doctors who are undergoing specialty training, and

WHEREAS residents play a key role in educating patients and medical students, and

WHEREAS residents are the physicians of the future and are committed to providing quality healthcare throughout the province, and

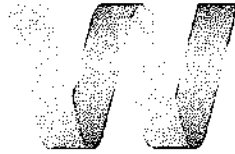
WHEREAS Our Lieutenant Governor, by and with the advice and consent of the Executive Council, has been pleased to enact Order in Council 903 on October 11, 2002;

NOW KNOW YE THAT We do by these presents proclaim and declare that February 15, 2016 through February 19, 2016, shall be known as

“Resident Awareness Week”

**BC WOMEN'S
HOSPITAL+
HEALTH CENTRE**

An agency of the Provincial Health Services Authority



**Genome
British Columbia**

Leading > Investing > Connecting

NEWS RELEASE

(Date to be confirmed: Week of January 25 or February 1)

From years to days – improving the accuracy and speed of diagnosis for genetic disorders in British Columbia's Neonatal Intensive Care Units

Copyright

Contacts:

Sacha Kennedy
Communications Manager
Genome BC
Mobile: 778-873-1240
Email: skennedy@genomebc.ca
#genomebc
@genomebc

Corinne Crichlow
Communications Officer
BC Women's Hospital + Health Centre
Mobile: 604-928-7857
Email: corinne.crichlow@phsa.ca



200 - 1333 West Broadway Vancouver, BC V6H 4C6 TEL: 604.736.5909 FAX: 604.736.2715
www.heabc.bc.ca

FOR IMMEDIATE RELEASE

January X, 2016

Nominations open for 2016 BC Health Care Awards
Event recognizes outstanding achievements in health care delivery across the province

Copyright

Page 0373 to/à Page 0403

Withheld pursuant to/removed as

s.16

Page 0404 to/à Page 0414

Withheld pursuant to/removed as

s.13.s.16

Page 0415 to/à Page 0545

Withheld pursuant to/removed as

s.16

Page 0546 to/à Page 0551

Withheld pursuant to/removed as

s.13.s.16

Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying

Final Report
November 30, 2015

Letter from the Co-Chairs

On behalf of our colleagues on the Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying (Advisory Group), we are pleased to submit this report of final key recommendations to the eleven participating provinces and territories, via the Ontario Minister of Health and Long-Term Care and Attorney General.

We have done our best, under challenging time constraints, to consult with as many stakeholder groups and individual experts as possible. Although physician-assisted dying is legal in many other jurisdictions, we believe we have come up with recommendations that will create a uniquely Canadian approach to this important issue.

The recommendations included are based on the best available evidence and the diverse expertise of the Advisory Group members.

Thank you for the opportunity to provide advice on this important issue.

Sincerely,

Dr. Jennifer Gibson
Co-Chair

Maureen Taylor
Co-Chair

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Acknowledgments

The Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying wishes to acknowledge the 11 provinces and territories that came together with a vision of creating a pan-Canadian approach to physician-assisted dying. These partners provided vital support and feedback to our secretariat throughout the process and it has been a highly collaborative and rich experience.

We would especially like to thank the secretariat provided to us by the Ontario Ministry of Health and Long Term Care (MOHLTC) and the Ministry of the Attorney General. This team of bright individuals worked long hours, evenings and weekends, to coordinate, research, strategize and keep us to deadline. It cannot be easy to follow the track changes of nine editors, but they managed this without complaint. We are grateful for their patience, their guidance and their dedication.

Finally, our work could not have been accomplished without the individuals and groups across Canada, who shared their time, expertise, and experience with us. Although we heard a diversity of views and perspectives on how physician assisted dying should be implemented, we also observed a tremendous generosity of spirit and willingness to engage, understand and bridge across differences.

Foreword

Twenty years ago Sue Rodriguez asked “Whose body is this? Who owns my life?” Having been diagnosed with Amyotrophic Lateral Sclerosis, Rodriguez wanted the option of aid in dying when her suffering became unbearable. Her request to the Supreme Court of Canada was denied by a narrow margin in 1993, but since then polls have consistently demonstrated growing public support for the option of medically-assisted death. The highly visible efforts of Canadians such as Gloria Taylor, Kay Carter and Dr. Donald Low, to exercise control over their lives and deaths have contributed to a seismic shift – both legal and social – in our country’s approach to end-of-life decisions.

The Government of Quebec took the lead on this issue, launching extensive public consultations and non-partisan discussions which resulted in Bill 52 – *An Act respecting end-of-life care*. In Québec, physicians will start offering qualifying patients the option of medical aid in dying in December 2015.

The rest of Canada will not be far behind.

On February 6, 2015, the Supreme Court of Canada rendered its decision in *Carter v Canada (Attorney General)* (“*Carter*”).

The Supreme Court unanimously struck down the *Criminal Code* prohibitions against assisted dying to the extent that they prohibited physician-assisted dying for a competent adult person who (1) clearly

consents and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The Court held that the prohibition on physician-assisted dying deprived the claimants and others suffering from grievous and irremediable medical conditions of the right to life, liberty and security of the person. The Court further held that this prohibition was overbroad and could not be justified in a free and democratic society.

The declaration of invalidity was suspended for 12 months (until February 6, 2016) to allow federal, provincial and territorial governments to respond, should they so choose, by enacting legislation consistent with the parameters set out in the Supreme Court's decision. Complementing any potential federal response, each province and territory must decide whether to enact legislation and/or adopt policies to clarify the rules affecting the provision of physician-assisted dying in its jurisdiction in light of the Supreme Court's decision.

Stakeholders hold diverse opinions on physician-assisted dying. While the majority of Canadians are supportive of the *Carter* decision, the idea of physician-assisted dying remains ethically challenging for some. As well, important values are at stake (and potentially in conflict) with respect to various elements that comprise the proposed regulatory framework for physician-assisted dying.

Acknowledgement of the differing ethical positions on physician-assisted dying in general and a careful ethical analysis of specific issues related to implementation must accompany the development of any policies, legislation and regulations.

Given this context, on August 14, 2015, eleven participating provinces and territories appointed a nine member Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying ("Advisory Group"). Participating jurisdictions include: Alberta, British Columbia (as an observer), Manitoba, New Brunswick, Newfoundland and Labrador, Northwest Territories, Nova Scotia, Nunavut, Ontario, Prince Edward Island, Saskatchewan, and Yukon.

A federal External Panel, established to provide options for a federal legislative response to *Carter*, was recently asked to deliver a report by December 15, 2015, outlining feedback received to date, but without any policy advice or legislative recommendations. With this in mind, our report includes recommendations that ask provinces and territories to advocate for certain changes to federal legislation.

Overview of Recommendations

The Advisory Group is grateful to the large number of individuals and groups from across the country who shared their time, expertise, experience and advice with us as we developed our final recommendations. Below we provide an overview of our key recommendations.

Physician-assisted dying is a critical social policy issue for our generation. We believe strongly that the introduction of physician-assisted dying should be part of a larger discussion about high quality and

equitable access to end of life care in Canada. Specifically, we recommend that provincial, territorial and federal governments should work together to develop a pan-Canadian strategy for palliative and end-of-life care. This strategy would include physician-assisted dying as part of a continuum of services and supports to Canadians at the end of life.

Effective February 6, 2016, all provinces and territories must ensure access to physician-assisted dying. Provinces, territories, and the federal government, along with professional regulatory authorities, should work together toward the common goal of a harmonized, effective, and equitable regulatory framework for physician-assisted dying. This will involve an array of actions by a variety of government, regulatory, institutional and professional actors detailed in our report. A strong legislative response is essential.

Although the *Carter* decision refers only to physician-assisted dying, and we adopt this term in our report, the Advisory Group feels strongly that other health professionals – notably nurse practitioners, registered nurses and pharmacists – will need to be involved in the process of physician-assisted dying. Given increasing emphasis on interprofessional team practice as a standard of care in some settings, consideration of other health professionals will be necessary to ensure equal access and high quality of care. This is reflected in our recommendations.

Our recommendations place the patient at the centre. We have outlined a pathway for the provision of physician-assisted dying, including who should have access, how patients may request physician-assisted dying, how eligibility criteria should be assessed, and where physician-assisted dying may be provided. We recommend safeguards to protect vulnerable populations, including those who may face social factors that may impair a patient's ability to make a truly autonomous choice. These safeguards include assessment by two physicians, reflection to ensure all eligibility criteria are met, robust assessment of competency and consent, and a witnessed patient declaration form that serves as a formal request for physician-assisted dying.

The *Carter* ruling underscored the need to reconcile the interests of patients and providers. As we explain in this report, health care providers have the freedom to object to the provision of physician-assisted dying for reasons of conscience, but they are required to provide information about *all* end-of-life options, including physician-assisted dying. Conscientiously objecting health care providers are also required to either provide a referral, a direct transfer of care to another health care provider, or to contact and transfer the patient's records through a third party, agency or service which would have a duty to ensure the safe and timely transfer of care of the patient to a non-objecting provider.

Health institutions, including regional health authorities and other institutional providers (e.g., hospitals, hospices and long-term care facilities) are critical enablers of effective and equitable access to physician-assisted dying. Non-faith-based institutions should have an obligation to provide physician-assisted dying and faith-based institutions should have an obligation to either provide physician-assisted dying or make arrangements for a safe and timely transfer of the patient to a non-objecting institution. Regardless of how the process unfolds, we believe that there must be continuity of care for the patient.

It is essential for a properly functioning regulatory framework that there is robust and independent oversight: to monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. We recommend two levels of oversight: a Review Committee at the provincial/territorial level and a pan-Canadian Commission on End-of-Life Care at the national level.

Finally, physician-assisted dying is new to Canada. There is a need to build and sustain effective capacity, including through research and continuing quality improvement, health professional education and training, and public education and engagement.

List of Recommendations

Section/Sub-Section	Recommendations
End-of-Life and Palliative Care	
	Recommendation 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.
Collaboration and Coordination	
	Recommendation 2: Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.
Access	
Critical Enablers of Access to Physician-Assisted Dying	Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation. Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying. Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying. Recommendation 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing. Recommendation 7: Provinces and territories should request that the federal government amend the <i>Criminal Code</i> to explicitly protect those health professionals who provide

Section/Sub-Section	Recommendations
	supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying. Recommendation 8: Provinces and territories should request that the federal government amend the <i>Criminal Code</i> to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying. Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying. Recommendation 10: Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.
Pathway to Provision	
Request and Documentation	Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party. Recommendation 12: Provinces and territories should request that the federal government make it clear in its changes to the <i>Criminal Code</i> that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.

Section/Sub-Section	Recommendations
	Recommendation 13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid. Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient. Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request. Recommendation 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).
Assessment of Eligibility	Recommendation 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the <i>Criminal Code</i> that eligibility for physician-assisted dying is to be based on competence rather than age. Recommendation 18: "Grievous and irremediable medical condition" should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as "grievous and irremediable" should not be delineated in legislation or regulation. Recommendation 19: Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural

Section/Sub-Section	Recommendations
	safeguards have been respected. Recommendation 20: Physicians should use existing processes in the health care system to assess competency and consent. Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.
Review	Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met. Recommendation 23: Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment. Recommendation 24: For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used. Recommendation 25: We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.
Provision	Recommendation 26: We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual. Recommendation 27: Physician-assisted dying should be available wherever patients live (including in hospitals, long-

Section/Sub-Section	Recommendations
	term care facilities and at home), except certain conscientiously objecting facilities. Recommendation 28: There should be no requirement that a physician be present at a self-administered assisted death.
Reporting	Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures. Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.
Role of Conscientiously Objecting Health Care Providers	
Duty to Inform	Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs. Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner.
Duty to Care for the Patient	Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4.

Section/Sub-Section	Recommendations
Role of Institutions	
Duties of Institutions	Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision. Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission. Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.
Duties of Non Faith-based Institutions	Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.
Duties of Faith-based Institutions	Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.
Oversight	
	Recommendation 39: Provincial and territorial governments should establish a Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

Section/Sub-Section	Recommendations
	Recommendation 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-Life Care to provide system oversight and to report to the public.
Research and Continuing Quality Improvement	
	Recommendation 41: There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.
Health Professional Education and Training	
	Recommendation 42: Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.
Public Education and Engagement	
	Recommendation 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

INTRODUCTION

Advisory Group

Mandate

Our mandate is to provide non-binding advice to participating Provincial-Territorial Ministers of Health and Justice on issues related to physician-assisted dying. The advice is meant to assist provinces and territories in deciding what policies and procedures should be implemented within their jurisdictions in response to the Supreme Court's decision in *Carter*.

In developing our recommendations, our starting point was the *Carter* decision and we have (to the best of our abilities) provided recommendations that are consistent with the *Criminal Code*, the Canadian *Charter of Rights and Freedoms*, provincial/territorial Human Rights Codes and other applicable laws. We reviewed key health care policy questions related to, among other issues, eligibility criteria, conscientious objection, procedural safeguards, access and oversight. As part of this review, we invited written submissions from key stakeholder groups in the fields of health care, law and ethics, and from a range of patient, professional, regulatory and health care provider perspectives. We also sought extensive additional input and advice from targeted experts and stakeholders.

We recognize that provincial and territorial governments will retain final decision-making authority over whether to accept our recommendations and how physician-assisted dying should be implemented within their respective jurisdictions. This advice is not binding on participating or non-participating jurisdictions, and each government will maintain its authority to respond to the *Carter* decision as it deems appropriate.

Composition

Advisory Group members hold a wide variety of positions on physician-assisted dying and bring a range of professional expertise on key clinical, legal and ethical issues (see Appendix 1 for full biographies).

Jennifer Gibson (Co-Chair) - Director of the University of Toronto Joint Centre for Bioethics and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto

Maureen Taylor (Co-Chair) - Physician Assistant in Infectious Diseases and Medical Journalist

Doug Cochrane - Patient Safety and Quality Officer for British Columbia and Chair of the BC Patient Safety and Quality Council

Jocelyn Downie - Professor in the Faculties of Law and Medicine at Dalhousie University

Ruth Goba – Human Rights Lawyer/Commissioner, Ontario Human Rights Commission

Nuala Kenny - Professor Emeritus of Bioethics at Dalhousie University and Former Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada

Arthur Schafer - Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Trevor Theman - Registrar of the College of Physicians & Surgeons of Alberta

Karima Velji - President of the Canadian Nurses Association and Integrated Vice President, Mental Health Services, for London Health Science Centre and St. Joseph's Health Care London

Process

The Advisory Group conducted its work from late August to November 2015. This included four face-to-face meetings in Toronto and numerous teleconferences. Our work was informed by background briefings on physician-assisted dying and significant stakeholder engagement.

Background Briefings

Background briefings included:

- a legal analysis of the Supreme Court decision and a review of the division of powers with respect to law and health care between Canada's federal government and its provinces and territories;
- a comparative analysis of the implementation of physician-assisted dying internationally in Belgium, the Netherlands, Luxembourg, Switzerland, Oregon, Washington State and Vermont;
- a literature synthesis on key issues related to physician-assisted dying; and
- a review of publicly-accessible policy documents regarding physician-assisted dying from Canadian provider and other stakeholder groups.

Stakeholder Engagement

The Advisory Group engaged a broad range of stakeholder perspectives in two phases. In the first phase, we invited over 250 stakeholder groups in September 2015 to complete written submissions on a wide range of issues related to the implementation of physician-assisted dying in Canada. Invited stakeholders included: provider associations, professional regulators, faith-based groups, patient, social, and legal advocacy groups, health institutions, and academic and other groups (see Appendix 2 for a list of stakeholders consulted). Stakeholders provided input and advice on issues related to:

- eligibility criteria;
- procedural safeguards;
- the role of physicians and other health care providers;
- conscientious refusal by health care providers;
- the role of institutions;
- access issues;
- settings for the provision of physician-assisted dying; and
- case review and system oversight.

In the first phase, we also met with representatives from the Government of Québec to learn about that province's experience with public and stakeholder consultations, crafting legislation, and working with health care professionals, facilities and others on the implementation of physician-assisted dying, and with the Governments of Nunavut, Yukon and the Northwest Territories to gain an understanding of the unique issues of the northern territories regarding the implementation of physician-assisted dying.

In November 2015, the Advisory Group conducted a second phase of consultations to clarify specific implementation issues. The Advisory Group invited panel discussions (in-person or by phone) with experts and national stakeholders over two days in Toronto. These sessions brought together stakeholders with divergent positions on the implementation of physician-assisted dying and created an opportunity for meaningful dialogue between those holding conflicting views.

Deliberations

The Advisory Group comprised a diversity of perspectives on physician-assisted dying, which we sought to reconcile through our deliberations in light of the background briefings and stakeholder input. In some cases, this involved re-considering and sometimes putting aside deeply-held personal views to find common ground in the interest of Canadian patients and the public.

These recommendations represent our best advice for implementing a comprehensive system to respond to the decriminalization of physician-assisted dying in Canada.

We acknowledge that our recommendations will have to be revisited and may need to be revised upon action taken by the federal government in the near future. We urge provinces and territories to work closely with the federal government, with each other and with health professional regulatory authorities to ensure an efficient approach to planning, communication and implementation, as well as a harmonized regulatory framework. It is the Advisory Group's firm belief that synchronized regulation of physician-assisted dying is critical to the public interest.

We also recognize that time constraints may impede the full implementation of some recommendations by February 2016. However, we believe that it is incumbent upon provinces and territories to put in place a regulatory framework by February 2016 that best protects those who are vulnerable and ensures access for those who are eligible for physician-assisted dying.

Legal Context

Supreme Court Decision

Our recommendations were developed in response to the Supreme Court's decision in *Carter*. In its decision, the Court held that "Section 241(b) and s. 14 of the *Criminal Code* unjustifiably infringe s. 7 of the *Charter* and are of no force or effect to the extent that they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." Where the above-noted criteria are met, the *Carter* ruling serves as an exception – for physician-assisted dying – to the general prohibitions in the *Criminal Code* against aiding and abetting a person to commit suicide and consenting to having death inflicted upon them.

It is notable that the Supreme Court did not limit the ruling to those unable to take their own lives, to cases of terminal illness, or to people near death. The Court's declaration is also not restricted to physical illnesses, diseases or disabilities, and includes mental illness.

The Supreme Court agreed with the British Columbia Supreme Court that the risks sometimes associated with physician-assisted dying – especially the potential risks to vulnerable people – "can be limited through a carefully designed and monitored system of safeguards." Although the Supreme Court did not outline the framework for such a system in the *Carter* decision, it expressed confidence that such a system could be implemented in Canada.

The Court noted that "nothing in its decision would compel physicians to provide assistance in dying", but also said that "the *Charter* rights of patients and physicians will need to be reconciled." The Court expressly left open the question of how to reconcile the rights of patients who seek physician-assisted dying with the religious or conscientious objections of physicians to participate in it. The Court was silent on the issue of whether institutions have any right to refuse to allow the provision of physician-assisted dying or otherwise participate in the provision of physician-assisted dying.

Several key terms were also left undefined in the Court's decision, including "adult" and "grievous." While the Court did not explicitly define "irremediable", the Court did clarify that "irremediable... does not require the patient to undertake treatments that are not acceptable to the individual."

Division of Powers

It is important to understand the federal and provincial/territorial division of powers to appreciate fully the context of our recommendations and any possible provincial/territorial action on physician-assisted dying.

In Canada, health is an area of shared federal and provincial/territorial jurisdiction. The federal Parliament may enact laws in relation to health care under its criminal law power (e.g., restricting

controlled drugs, prohibiting certain practices). The provinces and territories, on the other hand, may legislate in relation to health care with their powers over health insurance, the regulation of health professions, and hospitals.

If there is no inconsistency between a valid federal law and a valid provincial/territorial law relating to health, then both laws apply. In the event of an inconsistency between a valid federal law and a valid provincial/territorial law, the federal law applies and the provincial/territorial law is inoperative to the extent of the inconsistency. “Inconsistency” in this case means either that there is a conflict in operation between the two laws (e.g., the federal law says a person must do something while the provincial/territorial law says the person must not do that thing) or that the provincial/territorial law frustrates the purpose of the federal law.

The federal Parliament may (subject to the *Charter*) use its criminal law power to stipulate the circumstances under which physician-assisted dying is permitted and to prohibit physician-assisted dying in other circumstances. Provinces and territories cannot enlarge or restrict the circumstances in which physician-assisted dying is permitted beyond those validly provided for by Parliament. The criminal law power allows Parliament not only to enact prohibitions, but also gives Parliament a measure of regulatory authority as well. However, because there are some health matters of exclusive provincial jurisdiction, there is a limit to how detailed or “regulatory” the federal law can be. As outlined in the Supreme Court’s reference to the *Assisted Human Reproduction Act*, criminal laws for the protection of health must address a “legitimate public health evil” rather than merely set uniform national standards for otherwise-beneficial medical activities. Parliament could establish physician-assisted dying rules aimed at reducing a risk of serious harm (e.g. rules ensuring that consent is unambiguous), but could not set medical standards unrelated to any risk of harm (e.g., Parliament could not regulate the referral or transfer-of-care obligations of physicians who object to physician-assisted dying on religious or conscientious grounds).

It is not possible to identify in the abstract a “bright line” past which valid federal criminal law turns into an invalid interference with provincial control over health. If the federal government sought to enact detailed regulations concerning the practice of physician-assisted dying (e.g., prescribing only certain permissible methods or drugs to be used in carrying out physician-assisted dying), it would need to be able to respond to any legal challenge to its regulatory authority by demonstrating with persuasive evidence that such regulations were aimed at addressing a legitimate public health evil. Provided that provincial/territorial laws were not inconsistent with valid federal legislation or with the *Charter*, provinces and territories could regulate aspects of physician-assisted dying not prohibited by federal law. For example, provinces and territories could enact legislation to regulate in relation to at least:

- eligibility (including rules regarding who may determine eligibility);
- determining competency and obtaining consent;
- safeguards to protect the vulnerable;
- settings in which physician-assisted dying is permitted;

- provider participation, including health institutions and both physicians and non-physician health professionals;
- means of delivery of physician-assisted dying;
- insurance (life and professional liability);
- certification of death; and
- reporting requirements and quality review.

Statement of Principles and Values

In developing our recommendations, we relied on a number of principles, values and existing rights, freedoms, responsibilities and obligations that exist in our health care systems. Some of these are enshrined in the *Charter of Rights and Freedoms* or provincial/territorial Human Rights Codes, while others are expressed in the Codes of Ethics of health care provider organizations. They all informed our work and form the basis for the recommendations in this report.

Individual and Institutional Rights and Duties

- The right to patient autonomy in end-of-life care decision-making
- The rights of freedom of conscience and religion
- The duty of health care providers to care for patients and not abandon them
- The right of Canadians to equitable access to health services
- The right to protection from discrimination as outlined in provincial Human Rights Codes
- The right to privacy
- When rights conflict, they must be reconciled

Pan-Canadian Principles

- Physician-assisted dying is one option in the end-of-life care continuum
- Canadians need access to high-quality palliative and end-of-life care
- Canadians need a harmonized system across the country
- Health care providers need clear guidance on rules, regulations and reporting requirements
- Transparency should be an ongoing goal whenever possible

In developing our recommendations, we also relied upon a set of beliefs with respect to regulation.

We believe that there are three critical actors in the regulatory system for physician-assisted dying: the federal government, the provincial/territorial governments, and the health professional regulatory bodies.

We believe that harmonization of regulation across jurisdictions is critical to the public interest and that an effective and efficient oversight system is essential to ensure responsible governance and trust in the regulatory system. A weak regulatory system would fail to meet the reasonable expectations of Canadians, including patients seeking physician-assisted dying and their loved ones.

We believe a strong legislative response is needed to ensure access to physician-assisted dying for all individuals who meet the eligibility criteria, to ensure that physician-assisted dying is provided only to individuals who meet the eligibility criteria, and to reconcile the sometimes competing interests of health care providers and institutions and patients (see Appendix 3 for a full list of recommendations that the Advisory Group believes should be implemented through

provincial/territorial legislation). We also believe that health professional regulatory authorities will play a critical role in the implementation of physician-assisted dying and their role in implementation will help to integrate physician-assisted dying into existing end-of-life processes and mechanisms (as much as possible and consistent with the physician-assisted dying legislation).

We believe that intergovernmental and cross-jurisdictional collaboration is essential. Of significance is the willingness by the new federal government to work collaboratively, as expressly set out in the Mandate Letter of the federal Minister of Justice, which urges the Minister to “lead a process, supported by the Minister of Health, to work with provinces and territories to respond to the Supreme Court of Canada decision regarding physician-assisted death.” We strongly encourage the provinces and territories to take up this invitation. Physician-assisted dying rests at the intersection of jurisdiction between the federal and provincial/territorial governments, as well as at the intersection of jurisdiction between the provincial/territorial governments and the professional regulatory authorities. Where there is a legitimate argument to be made that jurisdiction is shared or overlapping, we take the view that regulation should happen at the level with the greatest capacity for harmonization across the country, accountability, efficiency, and capacity for effective enforcement.

We believe the following three features are at the core of our call for a pan-Canadian regulatory framework:

1. Core elements established through the *Criminal Code*;
2. Additional procedural safeguards and provisions to ensure access established through provincial legislation (preferably based on a single model statute); and
3. Additional guidance for health care professionals established through their regulatory authorities (preferably based on model standards and guidelines developed collaboratively by the regulatory authorities).

Finally, we believe that physician-assisted dying should be integrated into existing end-of-life processes and mechanisms as much as possible. When faced with offering a new service, it can be tempting to create new systems to accompany the service. While physician-assisted dying is unique in some ways, it is also similar in many ways to existing procedures and can and should be treated as such. Physician-assisted dying should be treated as one appropriate medical practice within a continuum of services available at the end-of-life. Where we recommend different or additional processes or mechanisms, it is because we have concluded that they are necessary to appropriately balance the competing interests and values at stake and to ensure that the regulatory framework assures the trust of Canadians.

RECOMMENDATIONS

End-of-Life and Palliative Care

RECOMMENDATION 1: Provinces and territories, preferably in collaboration with the federal government, should develop and implement a pan-Canadian strategy for palliative and end-of-life care, including physician-assisted dying.

Canadians need better access to quality palliative and end-of-life care, and should be made more aware of the options currently available to them. These were common refrains in the written submissions we received, the face-to-face consultations we conducted, and during our own deliberations.

Many provinces and territories have long been working to improve access to quality palliative and end-of-life care within their own jurisdictions. The Advisory Group strongly recommends that this work be expedited and that provinces and territories develop and implement a pan-Canadian strategy to ensure consistent standards and adequate resources for meeting what should be a national priority.

We also heard some stakeholders suggest that a patient could not truly give free or properly informed consent to physician-assisted dying without first being aware of and having access to adequate palliative care. The Advisory Group understands that the validity of patient consent lies at the heart of the assessment of eligibility for physician-assisted dying and that lack of access to quality palliative care might, in some specific cases, threaten various elements of a valid consent. However, withholding physician-assisted dying from everyone until palliative care is available and offered to all is not the appropriate response, as it denies those who are eligible the right to die in the manner they choose. Instead, society should work tirelessly to improve access to quality palliative care and health care providers should ensure that, in each individual case, any consent to physician-assisted dying is free and informed and made by a competent individual within the constraints of the system.

Despite our recognition of the importance of a pan-Canadian strategy for palliative and end-of-life care, we do not believe the implementation of physician-assisted dying should be delayed. We believe that a better approach is to ardently promote palliative care while ensuring that health care providers are aware of the potential concerns related to patient consent (to physician-assisted dying) and are equipped to effectively address these concerns while respecting patient autonomy. Better palliative care should not be seen as a pre-condition for the development of a system that permits physician-assisted dying, but rather as a complement to improved end-of-life care.

Collaboration and Coordination

RECOMMENDATION 2: Provinces and territories should collaborate and coordinate with all relevant organizations and institutions as soon as possible to ensure the smooth and timely implementation of physician-assisted dying in Canada.

Many stakeholders who spoke to the Advisory Group were concerned about the uncertain impact of physician-assisted dying on the health care system and the negative consequences for patients and the public of a patchwork of approaches across the provinces and territories. The introduction of physician-assisted dying across Canada will inevitably raise issues that cannot easily be anticipated by government working alone. Early and active engagement with all impacted areas of the health care system will be required to identify and resolve these issues quickly.

The Advisory Group believes that the successful introduction of physician-assisted dying in Canada will require coordinated action by a number of organizations and institutions with various responsibilities within our health care systems. Provinces and territories should reach out to these groups immediately to ensure that all policies and planned changes within each jurisdiction are well-aligned and understood and that gaps and challenges are identified as quickly as possible. Key stakeholder groups include health care provider associations, health care facilities and institutions, insurers, the Canadian Institute for Health Information, the Vital Statistics Council of Canada, clinical specialty groups, academic institutions (e.g., faculties of medicine, nursing and pharmacy), and accreditation bodies.

We direct the attention of provincial/territorial governments to the actions around which collaboration and coordination is necessary to create a comprehensive system for physician-assisted dying (See Figure 1).

Figure 1. Necessary Activities of Other Organizations and Institutions

Health Authorities
• Develop plans for enabling access (e.g., privileges, payment, managing transfers of care)
Associations of Health Care Institutions
• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law
Health Institutions
• Develop or revise institutional policies and procedures for physician-assisted dying to be consistent with the law • If faith-based and objecting to physician-assisted dying, develop plan for transfer of patients to another institution
Professional Associations
• Revise Codes of Ethics to be consistent with the law
Specialty Clinical Groups (e.g., Critical Care, Family Medicine, Palliative Care)
• Develop clinical practice guidelines for physician-assisted dying
Royal College of Physicians and Surgeons of Canada, College of Family Physicians of Canada, and analogous bodies for Registered Nurses (including Nurse Practitioners) and Pharmacists
• Develop physician-assisted dying competencies • Develop physician-assisted dying education programs
Accreditation Bodies
• Develop standards regarding physician-assisted dying for professional schools (e.g., Medicine, Nursing, Pharmacy) • Develop standards regarding physician-assisted dying for health care institutions
Professional schools (e.g., Medical, Nursing, Pharmacy, Social Work, Law, etc.)
• Develop undergraduate, postgraduate, and continuing education curricula and materials on clinical, legal, and ethical aspects of physician-assisted dying
Vital Statistics Council for Canada and Provincial/Territorial Registrars of Vital Statistics
• Revise "agreed data set" for reporting to the Canadian Institute for Health Information • Develop data access plan for Review Committees and researchers
Canadian Institute for Health Information
• Design data collection and access systems to flow information from governments to researchers in consultation with Canadian researchers as well as researchers who conduct the regular studies in permissive jurisdictions
Insurers (Health Professional Liability Insurers, and Life and Health Insurers)
• Develop explanatory materials regarding life insurance coverage • Develop explanatory materials regarding liability insurance coverage for health professionals

Access

Barriers to Access

During our stakeholder consultations, we learned that there are many reasons why patients within the same province or territory might not have equitable access to the same health services, some of which are common to many health care services and some of which may be unique to the provision of physician-assisted dying.

Representatives of territorial governments and northern/remote communities repeatedly raised the issue of geography and the uneven distribution of health care professionals. Rural communities can also suffer from inadequate health infrastructure or resources. These access issues are not unique to the provision of physician-assisted dying. Indeed, we anticipate that the challenges already associated with the delivery of adequate health care in certain areas of the country will present themselves with the introduction of physician-assisted dying as well.

The introduction of physician-assisted dying brings with it the possibility of unique barriers to access. These may include inadequate training of health professionals on its appropriate implementation, fear of legal liability among physicians and other health professionals, and issues of conscience. Some stakeholders raised the possibility that cultural factors may affect access to physician-assisted dying in some settings and fear of social stigma in small communities may dissuade health care professionals from participation in the procedure. Other impediments to access may include language barriers, concerns about professional liability insurance or life insurance policies, and the costs of physician-assisted dying services.

Critical Enablers of Access to Physician-Assisted Dying

In this section, we recommend a series of critical enablers of access that are specific to physician-assisted dying. However, we believe it is important to recognize that ongoing attempts to improve access to an array of health care services and supports will also help to provide effective access to physician-assisted dying.

RECOMMENDATION 3: *All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.*

RECOMMENDATION 4: *Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.*

Physician-administered and self-administered physician-assisted dying is ultimately a communal responsibility of society, governments and health care professions. It should never rest solely on the

shoulders of individual health care providers or facilities. The burden of finding a physician or institution that is willing to assess and ensure eligibility and provide access to physician-assisted dying should never fall to the patient alone, regardless of their geographic location or whether they are in a hospital, hospice, or engaging with another part of the health care system.

We recommend the creation of a publicly-funded care coordination system to link patients with an appropriate provider of physician-assisted death. This system must be given the resources and legal authority necessary to ensure that patients do not face access barriers because of geography or physician supply or objection. This system would ensure that people in rural and remote communities have equitable access to physician-assisted dying (e.g., through physician visits and/or telemedicine services) and that those without a current primary care provider or with a conscientiously objecting physician still have the opportunity to receive care from a provider who will consider their eligibility for physician-assisted dying.

We recommend that this system be modelled on successful examples used in other health care services (e.g., cancer care, organ transplantation). We envision them as “patient navigators”, people who have an understanding of the field, knowledge of health care providers who are willing to provide physician-assisted dying to individuals who meet the eligibility criteria, and the interpersonal skills, resources, and legal authority to facilitate the transfer of care between health care providers (including the transfer of medical records so as to protect the identity of the health care providers accepting the patient). While the system’s initial role would be to connect patients to physicians and manage the transfer of patients, over time they may also assist with helping patients understand the range of end-of-life options available, including palliative care.

RECOMMENDATION 5: Provincial/territorial governments should publicly fund physician-assisted dying.

We believe that provincial/territorial governments should take steps to ensure that access to physician-assisted dying is not dependent on a patient’s ability to pay for the service. This will require that physician-assisted dying, including all aspects from counselling about end-of-life options to assessments and provision, are included as insured services under provincial and territorial health insurance plans.

RECOMMENDATION 6: Provincial/territorial governments should not allow physician-assisted dying to be on the exclusion list for interprovincial reciprocal billing.

Interprovincial billing agreements exist between provinces and territories for medically necessary insured hospital inpatient and outpatient services rendered in publicly-funded hospitals. All provinces and territories with the exception of Québec also participate in reciprocal billing arrangements for the payment of insured medically necessary physician services.

These agreements cover insured hospital and physician services for Canadians who are temporarily away from their province/territory of residence but are within Canada (e.g., travelling or on an approved absence for work or educational purposes). The agreements and the supporting billing system endeavour to ensure that the province or territory providing the service directly bills the patient's home province or territory, and that the patient is not required to pay directly for health services (provided the patient presents a valid health card). A small number of procedures have been placed on an exclusion list for interprovincial reciprocal billing. Physician-assisted dying is not analogous to the other services on the exclusion list and so should not be on this list.

While we recommend that all provinces and territories have a policy of providing access to physician-assisted dying, we recognize that in order to provide access to physician and hospital services in some rural and remote northern and border communities, there may be reliance on out-of-province/territory patient transfers and the interprovincial billing arrangements that support the related physician and hospital services. In addition, some individuals may wish to move from one province or territory to another for the last weeks or months of their lives in order to be near loved ones and caregivers. The Interprovincial Reciprocal Billing Agreement should not be allowed to create a barrier to access to physician and hospital services for them.

Our overall goal in making Recommendations 5 and 6 is to ensure that physician-assisted dying is an insured service for all eligible patients within Canada who qualify for publicly-funded health services. These recommendations would also mitigate concerns about international medical tourism within Canada, while still recognizing that some Canadian communities may not have the capacity to offer physician-assisted dying to their own residents, and that some patients may wish to move elsewhere within Canada towards the end of their lives.

RECOMMENDATION 7: Provinces and territories should request that the federal government amend the Criminal Code to explicitly protect those health professionals who provide supporting services during the provision of physician-assisted dying. This clarity will ensure the viability of a team-based approach to the provision of physician-assisted dying.

Our health care systems function best when teams of providers with diverse skills and scopes of practice work together to provide the best possible care for patients. The *Carter* decision permits physicians to provide physician-assisted dying within the circumstances of the decision, but is silent on the role of other health professionals. To ensure that all health professionals can provide quality care within their scope of practice as part of a team-based approach, we recommend that the federal government provide additional clarity in the *Criminal Code*. These *Criminal Code* changes should ensure that health professionals can provide the support services they normally would, including but not limited to a pharmacist dispensing a prescription, a nurse drawing medication into a syringe, or a personal support worker giving a patient prescribed medication.

RECOMMENDATION 8: Provinces and territories should request that the federal government amend the Criminal Code to allow the provision of physician-assisted dying by a regulated health care professional (registered nurse or, if applicable, physician assistant) acting under the direction of a physician, or a nurse practitioner. Provinces and territories should in turn ensure that no regulatory barriers exist that would prevent these health care professionals from providing physician-assisted dying.

While Recommendation 7 deals with the invaluable role other health professionals should be allowed to play in supporting the provision of physician-assisted dying, this recommendation deals specifically with the provision itself. Nurse practitioners have independent scope of practice to assess the patient and prescribe medication when appropriate. Where access to physicians or nurse practitioners is limited other regulated health professionals (registered nurses or, if applicable, physician assistants), acting under the direction of a physician, should be able to write the prescription or give the injection without exposure to criminal liability.

Given that, in the *Carter* decision, the Supreme Court referred only to physician-assisted dying, it will be important for any *Criminal Code* amendments to explicitly permit regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners, to facilitate adequate access across Canada. Without this clarity, non-physician professionals would face uncertainty about their role and would potentially be exposed to liability for providing physician-assisted dying. It will be essential that provincial/territorial scope of practice legislation does not create barriers to these health professionals providing physician-assisted dying.

Throughout this report, our recommendations refer to physicians when discussing the provision of physician-assisted dying. If the *Criminal Code* changes advocated for in this recommendation are adopted, these recommendations should be read to include regulated health professionals (registered nurses or, if applicable, physician assistants) acting under the direction of a physician, and nurse practitioners.

RECOMMENDATION 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

We view the appropriate protection of health care providers from liability as a way to promote access to physician-assisted dying. We heard from many stakeholder groups that if health professionals feel they are exposed to liability, they will be much less likely to provide physician-assisted dying.

This recommendation has two aspects. First, provinces and territories should ensure that necessary legislative or regulatory amendments are made to codify this protection. Health professionals who provide physician-assisted dying need to know that their participation will not expose them to liability as long as they are not negligent and act in good faith within the rules set out to support the implementation of physician-assisted dying. Second, provinces and territories should ensure that health care providers' liability insurance does not discriminate against providers based on whether or not they provide physician-assisted dying. Provinces and territories should work with the Canadian Medical Protective Association and other insurers of health professionals, and make any necessary legislative or regulatory changes to ensure that liability coverage is not affected by whether the provider participates in physician-assisted dying.

RECOMMENDATION 10: Provinces and territories should evaluate whether legislative or regulatory amendments are necessary to require life insurance claims to be paid for deaths resulting from physician-assisted dying. Where necessary to achieve that result, amendments should be made.

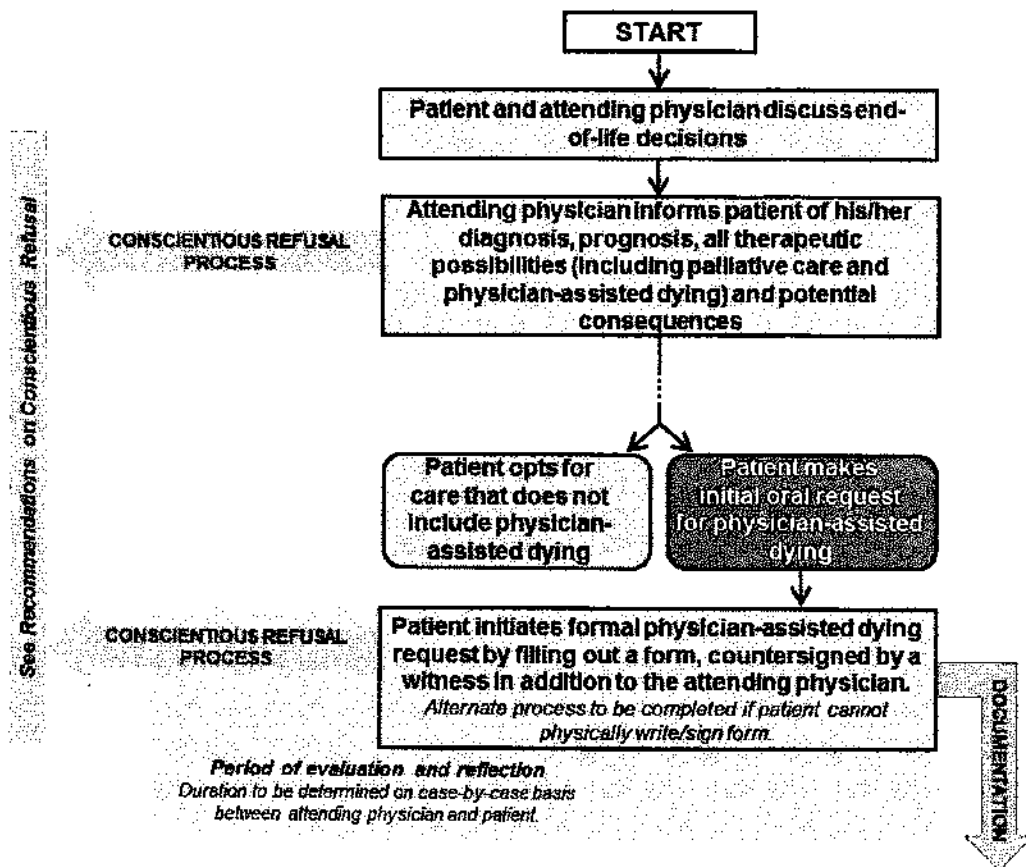
Life insurance payments can be critically important to beneficiaries after a patient has died. Provinces and territories should ensure that beneficiaries do not have life insurance claims rejected solely on the grounds of the benefactor receiving physician-assisted dying.

Pathway to Provision

In this section, we outline the process by which a patient may initially discuss their end-of-life options, request physician-assisted dying, go through a rigorous assessment process, and then, where the eligibility criteria are met and procedural safeguards observed, be provided with physician-assisted dying. Throughout this section, we will highlight areas where we have added additional safeguards to existing processes to protect patients and ensure that consent for such an important decision is free and informed and made by a competent individual. Graphical depictions of our proposed patient pathway are included throughout this section. A full version is included as Appendix 4. The pathway below describes the most common scenario; however, a modified approach may be required in some cases. Once we have outlined the standard patient pathway, we will examine the role of health care providers and faith-based institutions who object to physician-assisted dying for reasons of conscience.

Request and Documentation

Figure 2. Request and Documentation Pathway



The patient-physician relationship is founded on mutual trust, respect, knowledge, and understanding between the patient and his or her health care provider. Through the relationship, the physician gains a

medical and psychosocial understanding of the patient and the reasons for his or her wishes with respect to health care. This relationship is the basis for assessments of competency, knowledge of the medical condition or conditions affecting the patient, and the impact and natural evolution of potential treatments. This relationship provides the patient with an understanding of his or her condition and treatment options and provides the physician with the knowledge needed to assess the patient's competency in making a request for physician-assisted dying. This relationship may take time to develop.

In the context of the patient-physician relationship and the principles of their profession, health care providers have several duties that apply regardless of their personal position on physician-assisted dying. These duties include the duty to inform, the duty to care for patients, and the duty of non-abandonment. In practice, this means that any physician has a duty to discuss all end-of-life options with their patients, including physician-assisted dying, even if they themselves would not be willing to participate in it.

When a patient raises the issue of physician-assisted dying, his or her physician should engage in a meaningful dialogue with the patient on diagnosis, prognosis, all end-of-life options (including palliative care and physician-assisted dying) and their potential consequences. If the patient is willing and agrees, these conversations should also involve the patient's family and caregivers. Based on these discussions, if the provider is willing to participate in physician-assisted dying, they should move on together to the next step on the pathway. If the physician is unwilling to participate, or if in an institution that does not provide physician-assisted dying, the physician should trigger the conscientious objection process (see Recommendations 31-38 below).

Revocation

The patient can, at any time, rescind his or her request for, or consent to, physician-assisted dying either verbally or in writing.

Patient Declaration Form

RECOMMENDATION 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

The patient declaration form, developed by provinces and territories or an oversight body established by provinces and territories, must clearly state that the patient has been informed about his or her condition and all available options, understands the information and appreciates the consequences of the decision, and has requested physician-assisted dying. If the declaration is being completed before the patient is experiencing enduring intolerable suffering, it must also include a statement clearly explaining what the patient considers to constitute enduring intolerable suffering.

The patient declaration form must be signed by the patient and countersigned by an independent witness and the attending physician. Where a patient cannot physically write or sign the patient

declaration form, an alternative means may be used, such as a video recording. A documented patient declaration witnessed by an independent party will serve as formal confirmation of the patient's wishes and a means of providing assurances to the attending physician and other interested parties that the patient has clearly requested and consented to physician-assisted dying.

Timing of Completion of Declaration

RECOMMENDATION 12: Provinces and territories should request that the federal government make it clear in its changes to the Criminal Code that at any time following the diagnosis of a grievous and irremediable condition, a request for physician-assisted dying made through a valid patient declaration form may be fulfilled when suffering becomes intolerable.

RECOMMENDATION 13: Within one year, provinces and territories, in collaboration with the federal government, should study whether patient declaration forms completed prior to the diagnosis of a grievous and irremediable medical condition might also be considered valid.

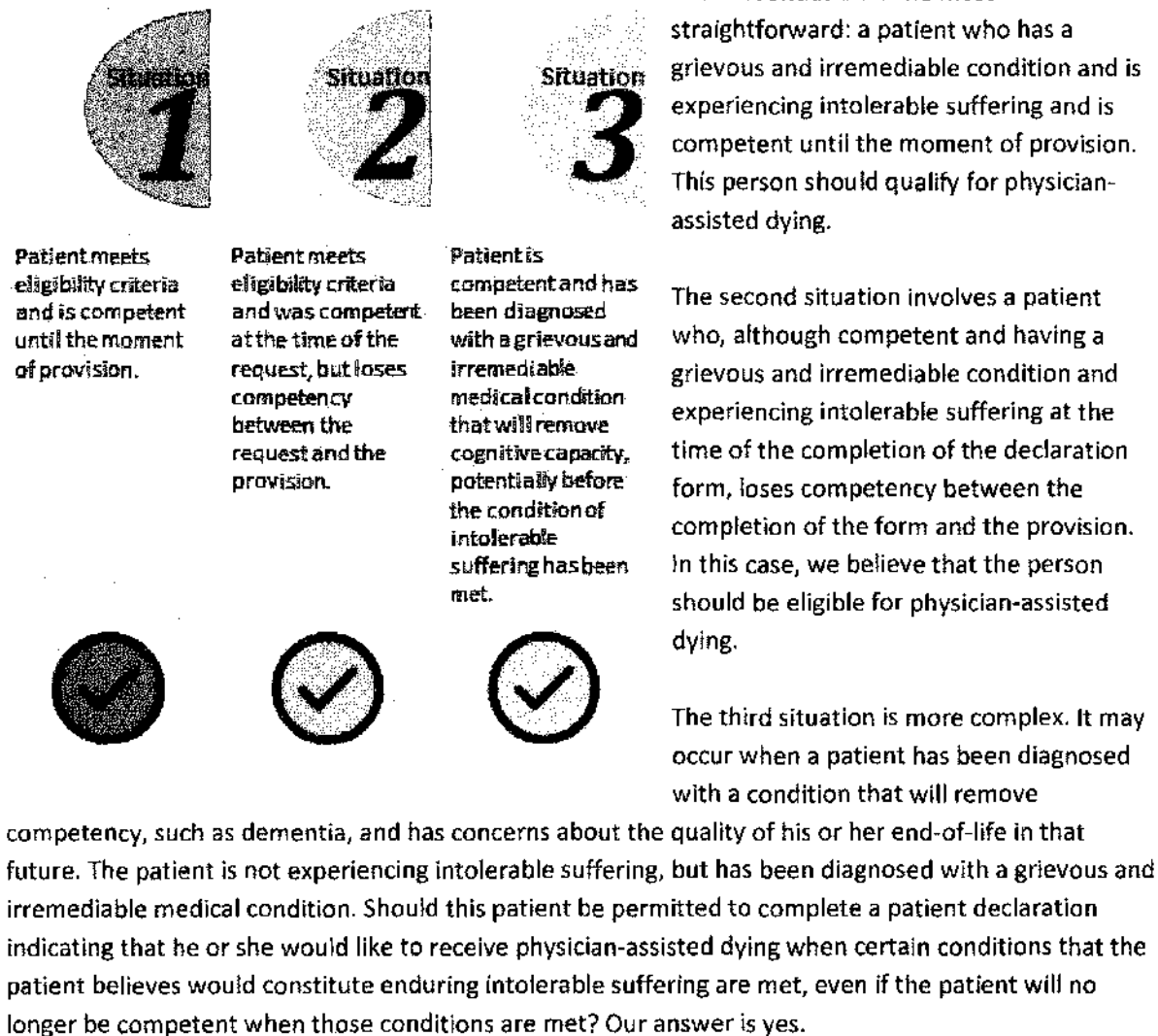
We have carefully considered the question of when the requirement for competency must be met. We have considered four possibilities and determined that physician-assisted dying should be permitted in three of those situations.

Provinces and territories should advise the federal government to make clear in the *Criminal Code* that physician-assisted dying is permissible where:

- a) the patient is competent at all times from the initial request to the moment of provision of assistance;
- b) although competent and having a grievous and irremediable condition and experiencing intolerable suffering at the time of the completion of the patient declaration form, the patient lost competence between the completion of the patient declaration form and the provision of assistance; or
- c) although competent and having been diagnosed with a grievous and irremediable condition, but not yet experiencing intolerable suffering, at the time of the completion of a patient declaration form, the patient lost competence between the completion of the patient declaration form and the onset of the enduring intolerable suffering.

We note that *Carter* requires that physician-assisted dying be provided to a competent adult. Scenario (a) above is clearly allowed under the Supreme Court of Canada's decision. However, the Supreme Court's decision is silent on scenarios (b) and (c) above.

Figure 3. Timing of the Completion of a Declaration



Particularly for certain degenerative diseases, we feel that to require that these patients be competent at the time physician-assisted dying is delivered would force many of them to trigger the act earlier in the course of their disease than necessary. Some people may be more comfortable with their diagnosis knowing that physician-assisted dying will be available to them after they lose competency. In such cases, physicians will need to take extra care to ensure that the patient understands and freely consents to his or her decision. The physician and patient should discuss the normal progression of the disease and how patients often respond and adapt to the disease. These conversations should continue throughout the progression of the disease (or up to the point of losing competence) to assess and confirm that the patient maintains his or her decision with respect to the future provision of physician-assisted dying.

We recognize that rules about advance directives vary across the country and, therefore, where a patient wishes to consent to physician-assisted dying in advance, the Advisory Group recommends that a standardized patient declaration form requesting physician-assisted dying be used instead of existing mechanisms. The patient's symptoms and/or presentation at the time of the provision of the assistance will need to be assessed against the criteria for intolerable suffering set out by the patient in advance.

There is a fourth, possible situation that we considered which involves a person who has not yet been diagnosed with a grievous and irremediable medical condition, but has completed a patient declaration form. We did not come to agreement on whether such a declaration should be considered valid consent for the purposes of eligibility for physician-assisted dying. Some members of the Advisory Group believe that this is consistent with existing practice with respect to advance care directives and so should be permitted, while others believe it is not possible to give informed consent to physician-assisted dying prior to a diagnosis of a grievous and irremediable medical condition. We therefore recommend that provinces and territories work with the federal government to consult further on this issue within the coming year and update legislation if needed by February 2017.

Substitute Decision-Makers

RECOMMENDATION 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Many stakeholder groups emphasized the paramount importance of patient autonomy as justification for respecting requests for physician-assisted dying. Allowing substitute decision makers to authorize/consent to this procedure on behalf of a patient leaves open the possibility that a patient's life could be ended in contravention, or without the explicit knowledge, of his or her wishes.

Patient Information Form

RECOMMENDATION 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

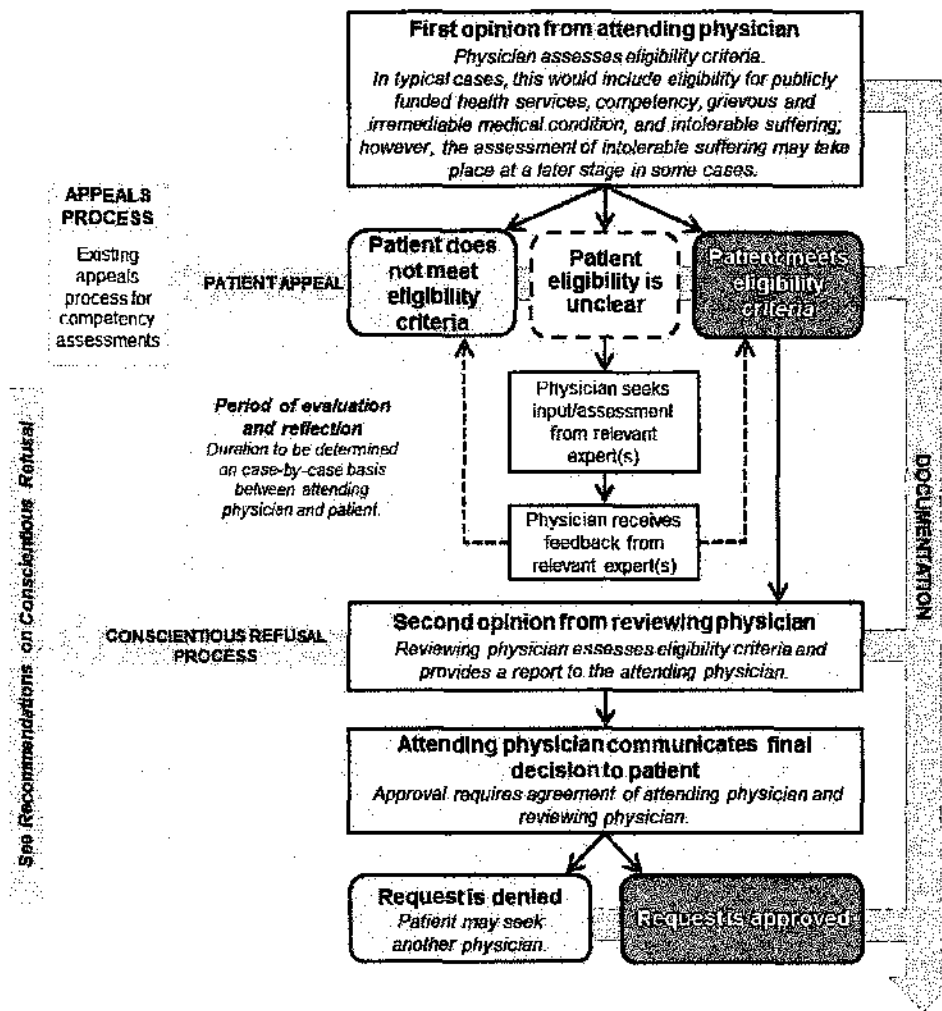
Patients who request physician-assisted dying should be asked to complete a simple form that outlines demographic information and their reasons for requesting physician-assisted dying. This information will be required by provinces and territories as part of an oversight system to be outlined later in this report. The de-identified information will also be relevant to researchers who choose to study the implementation of physician-assisted dying in Canada.

RECOMMENDATION 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).

Data should be collected from the patient's initial request to the time of signing the death certificate. In addition to the data gathered through the declaration form and information form, data should also be collected on the number of, and grounds for, refusals of patient requests for physician-assisted dying and the number of patients permitted physician-assisted dying that chose not to proceed. Data should be gathered by the attending physician as part of the request and assessment process and provided to the Review Committee and Oversight Body, outlined below.

Assessment of Eligibility

Figure 4. Assessment of Eligibility Pathway



The willing attending physician must ensure that the patient is eligible for physician-assisted dying based on the eligibility criteria set out in the *Carter* decision. According to the Court, a patient must be 1) an adult person 2) with a grievous and irremediable medical condition (including an illness, disease or disability) 3) that is causing enduring suffering that is intolerable to the individual in the circumstances of his or her condition. The court also required that the adult person be competent and clearly consent to the termination of life.

Adult Person

RECOMMENDATION 17: Access to physician-assisted dying should not be impeded by the imposition of arbitrary age limits. Provinces and territories should recommend that the federal government make it clear in its changes to the Criminal Code that eligibility for physician-assisted dying is to be based on competence rather than age.

The *Carter* decision applies to a “competent adult person,” but does not include a definition of adult. In assessing whether someone is an adult person, an arbitrary age limit such as 18 years old provides no valid safeguard. Instead, it is important that willing physicians carefully consider the context of each request to determine whether the person has the information needed, is not under coercion or undue pressure, and is competent to make such a decision.

Competence and consent to treatment laws vary among provinces and territories. In some cases, decisional competence is based on age, but in others, age is irrelevant to whether the patient has the legal authority to make decisions about his or her treatment.

An ideal regulatory framework for physician-assisted dying would have uniform eligibility rules. Indeed, many provider groups asked the Advisory Group to recommend a consistent national approach to eligibility for physician-assisted dying and patient advocacy groups also sought an easily understandable criterion for accessing the service regardless of where in the country a patient lives. The federal government could facilitate this by affirming that the definition of “adult” in the context of physician-assisted dying relates to a patient’s ability to give consent rather than a particular age cut-off. That is, to allow access to patients who are competent, regardless of age.

Grievous and Irremediable Medical Condition

RECOMMENDATION 18: “Grievous and irremediable medical condition” should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as “grievous and irremediable” should not be delineated in legislation or regulation.

RECOMMENDATION 19: Provinces and territories should request that medical regulatory authorities develop guidance/tools for physicians in order to ensure that criteria for access to physician-assisted dying have been met and procedural safeguards have been respected.

The second aspect of eligibility requires that the physician confirm that the patient is suffering from a grievous and irremediable medical condition. The Supreme Court does not offer a definition of “grievous” in the *Carter* decision. The Canadian Oxford Dictionary defines “grievous” as “very severe or serious.” This definition should be used in any changes proposed to the *Criminal Code*, provincial/territorial legislation or regulatory authority standards related to physician-assisted dying. Consistent with the *Carter* decision, we understand that “irremediable” is used to describe a condition that cannot be alleviated by any means acceptable to the patient. The determination of whether a condition is irremediable should be a two-step process. First, the physician must determine whether any treatments exist for the condition. Second, the patient must determine whether any of the available treatments are acceptable to him or her.

We heard consistently through the stakeholder engagement process that grievous and irremediable should not be defined in terms of specific health conditions. No list of specific conditions could capture the range of illnesses, diseases and disabilities that might meet the parameters established by the Supreme Court. Instead, we recommend that regulatory authorities develop tools to assist physicians in making this determination on a case by case basis.

Intolerable Suffering that is Enduring

The Supreme Court states that the medical condition must cause enduring suffering that is intolerable to the individual in the circumstances of his or her condition. This is a subjective test based on the patient’s response to his or her condition. In order to determine whether this eligibility criterion has been met, the physician must receive from the patient a very clear statement of what the patient considers or would consider to be suffering that is intolerable.

Competency and Consent

RECOMMENDATION 20: Physicians should use existing processes in the health care system to assess competency and consent.

During our consultations, we heard from some stakeholder groups who felt that a panel of doctors, a tribunal or judge, or a specially-trained professional should be required to conduct a vulnerability assessment for all persons with disabilities seeking physician-assisted dying. We also heard that a mental health assessment should be required for all persons seeking physician-assisted dying.

We share these group’s concerns about the protection of vulnerable populations and the need for safeguards to do so. However, our research and discussions lead us to believe that existing mechanisms

are sufficient to ensure that patients are making an informed choice and that physicians can effectively assess patient competence. In the text that follows, we describe the current systems in place to support informed consent and competency assessment and show how these systems can be applied to the implementation of physician-assisted dying.

Informed Consent

To be valid, consent must be free and informed. To be free, the person making the choice must not be subject to coercion or undue pressure. For consent to be informed in the context of physician-assisted dying, we follow the Federation of Medical Regulatory Authorities of Canada's advice in their June 6, 2015, guidance on physician-assisted dying:

The attending physician must disclose to the patient information regarding their health status, diagnosis, prognosis, the certainty of death upon taking the lethal medication, and alternatives, including comfort care, palliative and hospice care, pain and symptom control and other available resources to avoid the loss of personal dignity. The physician must advise the patient of any counselling resources that are available to assist the patient. The attending physician must inform the patient of his or her right to rescind the request at any time. The attending physician has an obligation to take reasonable steps to ensure that the patient has understood the information that has been provided.

Competency

To be competent to consent to treatment, the person must be able to understand information relevant to the decision and appreciate the nature and consequences of the specific decision being made or not made. Competence can fluctuate over time and a person may be competent for one decision (e.g., simple with minor consequences) but not another (e.g., complex with very serious consequences).

Assessment

In most cases where a person requests physician-assisted dying, there will be little doubt that his or her decision is free and informed and that the patient has the competence to make the decision to choose physician-assisted dying. In other cases, competency may be in question and there may be reason to doubt whether the decision is free and/or informed. Particular concerns that have been raised include those involving persons with psychiatric conditions, minors, and persons living with severe disabilities. For example, we heard concern from some stakeholders that individuals with psychiatric conditions or minors may not be capable of appreciating the consequences of the decision because of their mental condition or lack of life experience and not-yet-fully developed executive functions. There were those who felt individuals living with severe disabilities may be particularly vulnerable to coercion or make the choice because of a lack of social supports and few other options. As a consequence, some suggested that age, psychiatric illness, and disability should be exclusion criteria for access to physician-assisted dying (or should be subject to different regulatory requirements).

Governments undoubtedly have an obligation to protect individuals who might seek physician-assisted dying while they are not capable of making an autonomous choice. However, we do not feel those who fall into these categories should automatically be denied the right to access physician-assisted dying.

Instead, we acknowledge the need for heightened scrutiny during assessments of the eligibility criteria for physician-assisted dying in the face of any signals that might indicate compromised autonomy (including, but not limited to psychiatric illness, disability, or age). Just as they already do for other end-of-life decisions, where a health care provider has concerns, doubts, or uncertainty about whether an individual is competent and is making a free and informed choice, the provider should take whatever time and consult any additional experts as is necessary to reach the conclusion that the person does or does not meet the eligibility criteria. Health care providers must assess the components of a valid consent on a regular basis and often in circumstances in which the decision is complex and the consequences dire. The same skills (and time and additional expertise) that are used for assessing the elements of informed choice for other end-of-life decisions are transferable and adequate for making such assessments for the physician-assisted dying decision.

Although we do not recommend the use of age, psychiatric condition, or disability as exclusion criteria for access to physician-assisted dying (as described in Recommendation 18), we do recommend the development of better assessment tools for consent and competency (especially in relation to vulnerabilities associated with lack of social support for persons living with disabilities). We also recommend the development and implementation of educational materials designed to improve the capacity of health care providers to assess competency – particularly in the presence of potentially compromising conditions or social contexts. This approach will serve the objective of protecting individuals who might seek physician-assisted dying but are not capable of making an autonomous and informed choice. It will also have the added benefit of protecting individuals who might make other life-limiting decisions while not capable of making an autonomous choice (e.g., refusing life-sustaining treatment in the face of a traumatic injury).

Insured Persons

RECOMMENDATION 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

In addition to the criteria set out in the Supreme Court's decision in *Carter*, we believe that only patients who are eligible for publicly-funded health services should be considered eligible for physician-assisted dying. The *Carter* decision does not include citizenship, residency, or status as an insured person as an eligibility criterion for access to physician-assisted dying, but almost all jurisdictions where physician-assisted dying is legal limit access to the service in this manner. Although imposing a Canadian residency requirement would prevent residents of foreign countries from visiting Canada to receive physician-assisted dying, imposing limits based on citizenship or permanent residency status could also create a barrier to access for some in Canada. As a result, we recommend that all – and only – those eligible for publicly-funded health services also qualify for physician-assisted dying.

Review

Second Assessment

RECOMMENDATION 22: *Two physicians must assess the patient to ensure that all criteria are met.*

Patients who are enduring intolerable suffering and who meet all other eligibility criteria for physician-assisted dying should not have their suffering extended or compounded by an unnecessarily burdensome administrative process to access this service. We feel, however, that the approval of an attending and reviewing physician (or nurse practitioner acting within their scope of practice) is a reasonable safeguard to help ensure that a patient has indeed met the eligibility requirements for accessing physician-assisted dying and an appropriate step to help support the attending physician.

Following the request for physician-assisted dying and assessment of eligibility and competency by the attending physician, we recommend an additional safeguard be put into place for physician-assisted dying whereby a second physician assesses the patient for eligibility and provides a report to the attending physician. For this to be justifiable hurdle, and not an unjustifiable barrier, this recommendation is conditional upon our earlier recommendation that Criminal Code changes make it possible for other regulated health care professionals – in addition to physicians – be permitted to provide assistance in dying (see Recommendation 8).

RECOMMENDATION 23: *Where there is limited physician supply, provinces and territories should enable virtual physician assessments and visits using telemedicine services (or other video-based consultations), or if necessary, transport reviewing physicians to the patient for the second assessment.*

While we recommend that two physicians should be involved in ensuring that all criteria have been met, we recognize that some communities do not have access to local physicians at all. In these cases, provinces, territories or the regional health authorities should work to provide patients with access to physicians either through telemedicine, by bringing physicians into the community or, if the patient is willing, by transporting him or her to an area where physicians are available and willing to conduct the necessary evaluations.

Appeals and Dispute Resolution

RECOMMENDATION 24: *For decisions related to competency, existing mechanisms in the health care/legal system by which patients can appeal competency decisions should be used.*

Existing provincial/territorial mechanisms allow patients to appeal decisions related to competency and set out the circumstances in which a patient has a right to appeal. For example, in Ontario, if a physician

has determined that a patient is not competent to consent to treatment, the patient has the right to appeal to the Consent and Capacity Board. No new system to handle competency disputes is required for physician-assisted dying.

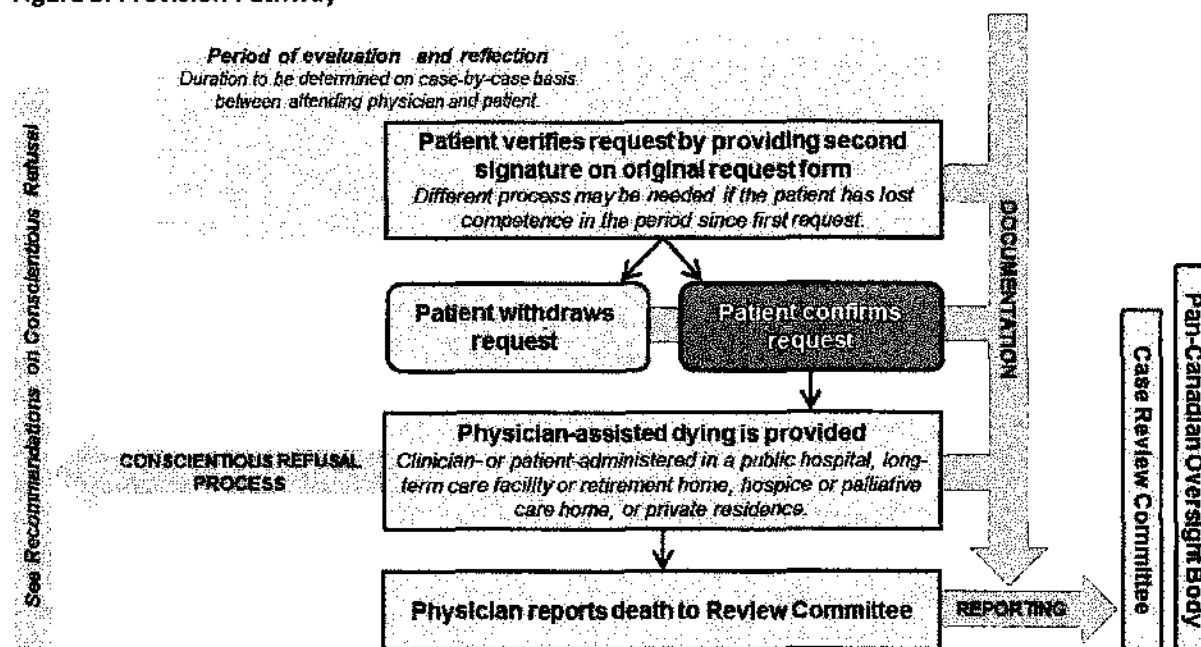
RECOMMENDATION 25: We do not recommend that an appeal process be established to respond to situations where the attending and/or reviewing physician conclude that the eligibility criteria (other than competency) have not been met. In this circumstance, patients should not be precluded from seeking assistance from other physicians.

We do not feel it necessary to set up an appeals process when the attending or reviewing physician concludes that the eligibility criteria (other than competency) have not been met. Instead we recommend the following:

- If the attending physician determines that the eligibility criteria (other than competency) have not been met, the attending physician shall inform the patient of the reasons for that determination. The patient should not be precluded from consulting another physician.
- If the reviewing physician determines that the criteria (other than competency) have not been met, the reviewing physician shall inform the patient and attending physician of the reasons for that determination. The attending physician or patient should not be precluded from seeking the opinion of another reviewing physician.

Provision

Figure 5. Provision Pathway



Once the reviewing physician has confirmed that the eligibility criteria have been met, the attending physician may request that the patient re-confirm his or her intention (if the patient is still competent) and the physician may provide physician-assisted dying to the patient.

RECOMMENDATION 26: *We do not recommend a prescribed waiting/reflection period. Rather, the time between initial request and declaration will vary according to the time it takes for the attending and reviewing physician to be confident that the declaration is free and informed and made by a competent individual.*

Several stakeholder organizations have requested that governments be prescriptive in setting out a specific waiting/reflection period as part of a clearly articulated physician-assisted dying process. Others have suggested this would not respect patient autonomy and physician judgement. While a mandated waiting/reflection period has been established in some jurisdictions, such as in the U.S. states that offer physician-assisted dying, we believe that such an approach would impose an arbitrary barrier to access that would negatively impact both patient decision-making and physician judgement.

Furthermore, a specific time period serves as a poor proxy for detecting decisions that are either not fully informed, not voluntary or made when a patient is not capable of fully appreciating the consequences of the decision being made. In some cases, a set time period may be too short for the physician to make a confident assessment of the elements of a valid consent. In other cases, it may be longer than is necessary.

As such, we do not recommend a particular prescribed time period. What is essential is that the patient has sufficient time to come to an informed and voluntary decision, to understand the information, and appreciate the consequences of his or her decision, and that the physician has had sufficient time to come to the conclusion that all of the eligibility criteria have been met. The time required to meet these conditions will vary depending on circumstances and so a set amount of time would be arbitrary. Furthermore, the passage of at least some time in every case is assured by the requirement that the attending and reviewing physicians both be confident that the consent is free and informed and made by a competent individual.

RECOMMENDATION 27: Physician-assisted dying should be available wherever patients live (including in hospitals, long-term care facilities and at home), except certain conscientiously objecting facilities.

Increasingly, Canadians express the desire to die in their own home and we believe both physician-assisted dying and palliative care should be delivered in the home if that is the patient's wish. In some cases, a patient's home may be a retirement facility, nursing home or hospice.

RECOMMENDATION 28: There should be no requirement that a physician be present at a self-administered assisted death.

Patients should have the right to choose who is present at their time of death. Therefore, there should be no requirement that a physician (or nurse practitioner acting within the scope of their practice) be present at a self-administered physician-assisted death. We recognize that self-administered physician-assisted dying may result in more complications than physician-administered physician-assisted dying. However, patients should be free to determine for themselves whether the benefits to them of allowing self-administration without a physician present outweigh the potential risks. Self-administration without a provider present may lead to more complications and adverse events, but research from other jurisdictions indicates that these events are extremely rare. Physicians should ensure that the potential risks are clearly explained to the patient and provide instructions on how to respond to them should they materialize.

Reporting

Case Review

RECOMMENDATION 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Although we do not support case review before provision of physician-assisted dying (as outlined in Recommendation 20), we believe that a regular review of individual cases after provision is required to confirm that all procedural safeguards have been followed correctly and to identify any systemic problems as soon as possible. Within 14 days of the provision of the assistance (either through the writing of a prescription or direct provision by a health care provider), the attending physician must file a report with the Review Committee (for details on the makeup and mandate of the Review Committee, see Recommendation 39). The Review Committee should have access to all patient files including the patient declaration form, patient information form, attending and reviewing physician's reports and additional competency assessments (if undertaken). Provinces and Territories should undertake any legislative or regulatory changes required to ensure that such health information can be shared with the Review Committee.

Vital Statistics

RECOMMENDATION 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.

Listing physician-assisted dying on medical certificates of death may require legislative changes in some jurisdictions, but we believe that it is an important step for tracking and data collection purposes to ensure full transparency. Physician-assisted dying should be listed as the manner of death. The name of the medical condition that qualified the person for physician-assisted dying should be reported as the underlying cause of death. The injection or ingestion of drugs should be recorded as an antecedent cause.

Provinces and territories should direct their Vital Statistics registrars to work together to ensure a common approach is used across Canada to ensure that system oversight can be efficient and effective (See Recommendations 39-40 regarding oversight).

Role of Conscientiously Objecting Health Care Provider

We have already outlined the process for the provision of physician-assisted dying when there are no conscientious objections being raised. We have also highlighted the duties and obligations of all health care providers, whether or not they object to the provision of physician-assisted dying. These duties include the duty to provide full information about all end-of-life options, including physician-assisted dying, the duty to care for the patient in a non-discriminatory manner and the duty of non-abandonment of the patient until such a time as care has been transferred to another provider.

These duties must be fulfilled by a conscientiously objecting health care provider. While we believe that there is a communal responsibility to provide access to physician-assisted dying, individual providers are not absolved of their personal/professional responsibilities, particularly in a publicly-funded system.

We believe that the positions set out below represent a respectful reconciliation of the many competing values at stake in the context of physician-assisted dying.

We believe that this reconciliation of competing values also harmonizes the approach taken across health professions (i.e., nurses' consciences are not given less weight than physicians'). We also believe that the burden of the risk of lack of access should not fall on patients. We believe that the burden of the risk of failure to ensure the design, implementation and maintenance of a system for arranging transfers of care from providers and institutions that object to providing physician-assisted dying should rest on those with the greatest power and voice to ensure that the government and other organizations design, implement, and maintain an effective and efficient transfer of care system (i.e., health care providers, professions, regulators and institutions rather than patients with grievous and irremediable conditions that cause enduring intolerable suffering).

Furthermore, we heard from health care provider organizations that, even without any legislation or regulation addressing the issue of conscientious objection, access to physician-assisted dying is likely not going to be a problem. We can draw a logical inference that a duty to inform and duty of non-abandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party) is, in their view, redundant.

We also heard repeatedly from groups representing individuals who want access to physician-assisted dying to be available that they believe that, without legislation establishing a duty to inform and a duty of non-abandonment (manifest as a duty to ensure an effective transfer of care either directly or through a third party), there may be problems with access. It is our hope that this approach will increase trust in the health care system among these individuals by setting out these duties in law. Health care providers will not be harmed by a redundant provision and members of the public who support access for physician-assisted dying will benefit. It therefore seems reasonable and prudent to enshrine the duties in legislation.

In developing the recommendations below, we have attempted to reconcile the patient's rights and freedoms (to conscience, autonomy, life, liberty and the security of the person) with the provider's (to conscience, religion/creed, and privacy). We have consulted extensively on these questions and have worked to create a system that ensures access without unnecessarily limiting the conscience rights of providers.

Duty to Inform

RECOMMENDATION 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs.

All end-of-life options (including palliative care and physician-assisted dying) should be discussed with patients in a respectful way regardless of the provider's beliefs. Such requirements are often already included in professional codes of ethics. For example, the Canadian Medical Association's Code of Ethics requires that physicians provide patients with the information they need to make informed decisions about their medical care.

RECOMMENDATION 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner.

Conscientiously objecting providers have a duty to inform new patients and, when appropriate, current patients of their position on physician-assisted dying. This allows patients to make an informed choice with respect to enrolling with or retaining that provider. Regulatory authorities and governments should produce educational materials for physicians and patients to help navigate these discussions. We also encourage all physicians to initiate and regularly revisit conversations with patients around advance care planning, the goals of care, and the patient's end-of-life wishes.

Duty to Care for the Patient

RECOMMENDATION 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4.

To facilitate access to physician-assisted dying, conscientiously objecting health care providers must refer, transfer care or contact a third party in a timely manner and transfer records to another health

care provider or third party, as required. There is no expectation that they will assess the patient's eligibility for physician-assisted dying.

We heard from some stakeholders who believed that a referral in the context of physician-assisted dying implied that the conscientiously objecting physician had assessed the patient, found them eligible for physician-assisted dying and was transferring care for the purposes of providing the service. While this is an option available to those who object to the provision of service, we did not want to imply that assessment is an obligation, or that this was the only option available to providers.

When we discuss a direct transfer of care, we envisage a situation where a patient has requested physician-assisted dying and has already discussed end-of-life options with their health care provider. We recognize that some providers view a transfer of care as morally preferable to referral because, unlike referral, it is taken to neither explicitly nor implicitly affirm the service sought by the patient. A health care provider could transfer the patient to another health care provider for the assessment and treatment of the patient's medical condition and, if the patient meets the eligibility criteria, provision of physician-assisted dying. The receiving health care provider must be someone who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. Following the transfer of care, the receiving health care provider would follow the pathway outlined earlier in this report.

For those conscientiously objecting health care providers who are not willing to provide a direct transfer of care on conscience or religious grounds, we provide the option of contacting and transferring the patient's records through a publicly-funded system designed to ensure that patients are able to access a health care provider willing to accept them as a patient for assessment and, if the eligibility criteria are met, to provide physician-assisted dying. If this system is not in place, conscientiously objecting providers should be required to make a direct transfer of care to a health care provider who is willing and able to accept the person as a patient and does not conscientiously object to physician-assisted dying. It is imperative that the burden of the transfer to another physician, institution or third party not fall on the patient seeking the care.

As described in Recommendation 4, we recommend a system where regional health authorities develop a publicly-funded care coordination system to help facilitate access to physician-assisted dying. One of this system's key functions should be to receive requests from unwilling or unable health care providers and transfer patients to providers who are willing and able to receive new patients.

Role of Institutions

Duties of Institutions

All institutions have certain responsibilities in common, many of which align with our recommendations related to physicians.

RECOMMENDATION 34: *All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.*

This recommendation will ensure that patients have clarity on what is permitted within the facility. They can then make informed decisions with respect to whether to enter or remain in the facility.

RECOMMENDATION 35: *Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.*

RECOMMENDATION 36: *Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.*

Taken together, the two recommendations above limit the power of institutions to restrict the autonomy of patients who may wish to seek physician-assisted dying at a later date, and providers, who may wish to provide physician-assisted dying outside a faith-based institution that does not offer physician-assisted dying. They represent an appropriate balance between patient and physician autonomy, patient access, and institutional autonomy.

Duties of Non Faith-Based Institutions

RECOMMENDATION 37: *Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.*

Governments have significantly more levers to influence the policies and practices of institutions that are funded in whole or in part by public funds. However, as a point of principle, we believe that physician-assisted dying should be available wherever people are living and dying. This includes privately-funded institutions. Recognizing that not all institutions will feel capable of providing physician-assisted dying for a variety of reasons, including size, geography and mandate, we concluded that institutions should be permitted to offer a patient transfer to another institution, as long as the receiving institution can and will provide a health care provider who is willing and able to accept the

person as a patient, to assess whether the criteria for access to physician-assisted dying have been met, and provide physician-assisted dying where the criteria for access have been met.

Duties of Faith-Based Institutions

RECOMMENDATION 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and, potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Faith-based institutions have a duty to care for and not abandon the patients within their institution. While they should not be required to provide access to physician-assisted dying, they must still ensure access for patients who wish to seek it.

When a patient makes a request for physician-assisted dying, faith-based institutions should be required to either allow for the assessment and provision of physician-assisted dying within the institution or make arrangements for an effective transfer of the patient to a non-objecting institution. This transfer must also include the transfer of all relevant records, and must be made to a non-objecting institution where the patient's medical condition can be assessed and treated by a health care provider who is willing and able to assess whether the patient meets the eligibility criteria for physician-assisted dying and, if so, can provide assistance. If a safe and timely transfer to a non-objecting institution is not possible, the objecting institution must allow an outside health care provider to assess the patient and, if the eligibility criteria for physician-assisted dying are met, to provide assistance. The receiving outside health care provider would follow the pathway for physician-assisted dying as outlined previously in this report.

Oversight

It is essential for a properly functioning regulatory framework that there is robust and independent oversight to: monitor compliance with relevant laws, policies and standards; to inform continuing development of policies and practices; and to ensure public confidence in the integrity of the system. To support the implementation of physician-assisted dying, we recommend two levels of oversight: one at the provincial/territorial level and one at the pan-Canadian level.

RECOMMENDATION 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

An independent review committee system should be established in each province and territory, or with agreement amongst groups of provinces and territories, to monitor compliance with the legal and regulatory framework for physician-assisted dying and to facilitate public reporting on physician-assisted dying in Canada. The Review Committees should include a physician, a legal expert, an ethicist, and a public representative who can determine whether the relevant laws and professional standards have been followed. Where issues arise, the Review Committees should report any potential violations to the appropriate authorities.

Individual cases should be reviewed after provision of assistance (see Recommendation 29). For each case of physician-assisted dying, the Review Committee will review the documentation submitted by physicians. As a starting point, we recommend that all cases be reviewed by the Review Committee. However, it may be possible for only a sample to be reviewed once the system of providing physician-assisted dying has matured in Canada. Where the Committee determines that the physician acted in compliance with the relevant laws and professional standards, the physician will be informed and the file will be closed. Where a physician is thought to have potentially violated laws or standards, the Review Committee will report this to the relevant professional regulatory authority for investigation and response under its professional self-regulatory powers. Any subsequent reporting by a regulatory authority to the police will follow the regulatory authority's normal processes with respect to reporting suspected violations of provincial or federal legislation. Where the Review Committee determines that a health institution or any other person was non-compliant with provincial/territorial legislation, it will refer the case to the relevant regulatory authority in its jurisdiction (e.g., regional health authority, Ministry of Health).

The Review Committee will also compile de-identified population-level data on physician-assisted dying in its jurisdiction. This may include incidence of physician-assisted dying, the underlying causes of death, the settings where physician-assisted dying was provided (e.g., hospital, home), the regulated health professional who provided the service (e.g., physician, nurse practitioner), the modality of physician-

assisted dying (i.e., self-administered or provider-administered), and any complications arising in the provision of physician-assisted dying. To facilitate pan-Canadian comparisons, common metrics should be developed for application across Review Committees.

The Review Committee should be required to prepare an annual report of its findings for the purpose of public reporting on physician-assisted dying at a provincial or territorial level and for submission to the pan-Canadian Commission on End-of-life Care.

RECOMMENDATION 40: Provincial and territorial governments should (preferably in collaboration with the federal government) establish a pan-Canadian Commission on End-of-life Care to provide system oversight and to report to the public.

A pan-Canadian Commission on End-of-Life Care should be established to report to the public on the implementation of physician-assisted dying. The Commission could be developed as part of a pan-Canadian strategy on palliative and end-of-life care, including physician-assisted dying, or it could be a separate body if a pan-Canadian strategy cannot be developed in a timely manner. It should report annually on things such as: the number of cases of physician-assisted dying; the number of requests for physician-assisted dying including those that were refused or never acted upon; and demographic data about who is requesting physician-assisted dying and why. These reports will help to ensure that the system in place is – and is seen to be – legitimate, trustworthy and non-discriminatory.

The Commission should also be given additional functions associated with a robust regulatory framework for physician-assisted dying including to:

- conduct or commission research it deems necessary in accordance with relevant federal, provincial, and territorial law and policy;
- consult with the public, health providers, and other experts on issues related to physician-assisted dying;
- inform the development and delivery of resources on moral, legal, and clinical aspects of physician-assisted dying to health care providers, legal professionals, and the public; and
- make recommendations to federal, provincial and territorial governments about potential law and policy reform with respect to physician-assisted dying in Canada.

Research and Continuing Quality Improvement

RECOMMENDATION 41: *There should be coordination across funders and federal/provincial/territorial governments on a research strategy to inform implementation and continuing development of end-of-life care, including physician-assisted dying, in Canada.*

Physician-assisted dying is a new practice in Canada. We are entering a critical phase in which evidence-gathering should be undertaken systematically and rigorously to inform responses to these Canadian questions. Although other jurisdictions provide insight into its practice, physician-assisted dying in the Canadian context raises unique policy and practice questions. There are unanswered questions, for example, about organ donation in the context of physician-assisted dying and the role and regulation of palliative sedation. Answering these questions will require the research community and governments to work collaboratively to advance a coordinated research agenda in service of Canadians.

Health Professional Education and Training

RECOMMENDATION 42: *Professional organizations, regulatory authorities and universities should collaborate with each other and with patient groups to develop appropriate curricula and continuing education programs and training for students, physicians and health professionals that are related to the provision of physician-assisted dying.*

A recurrent theme throughout our consultation with stakeholders was the need for education and training of health professionals with respect to physician-assisted dying, including its clinical, legal, and ethical aspects. Health professional education and training should include both undergraduate and post-graduate education, as well as continuing professional education of licensed health professionals. Health professional education should not be limited to regulated health professionals, but should also address the learning needs of other health care workers involved in patient care. Although some clinical specialties may be more likely to participate in the provision of physician-assisted dying, end-of-life conversations including about physician-assisted dying may arise in any therapeutic relationship between patients and providers. This suggests that physician-assisted dying and related end-of-life issues should be a core component of all health professional education. The curriculum should ideally include training on: how to talk with patients about physician-assisted dying; what the legal, regulatory, and ethical obligations are; the extent and limits of conscientious objection; the psychosocial aspects of illness; awareness of and sensitivity to cultural, linguistic, and other forms of diversity; and assessment of social vulnerability. Notably, this curriculum would be broadly relevant to the delivery of high quality end-of-life care and other clinical care.

Public Education and Engagement

RECOMMENDATION 43: Provinces and territories should provide public education about physician-assisted dying and apply best practices for public engagement to inform the continued development of end-of-life care law, policies, and practices.

Public education and engagement are critical to a transparent system of end-of-life care, including physician-assisted dying. There is a need for public education on what physician-assisted dying is (and what it is not), how it fits within a continuum of end-of-life services, how it can be accessed and under what conditions, and how physician-assisted dying is governed, administered, and monitored, including what safeguards are in place. Patients and families also need information about what supports and services are available for patients and their families at the end-of-life. While some of this information may be provided by physicians and other health professionals in conversation with their patients, such information should also be readily publicly available for patients and members of the public. There is also a need for patient and public engagement to inform the continuing development of high-quality end-of-life care and supportive care, and the implementation of physician-assisted dying. Current best practices in patient and public engagement should be proactively incorporated into provincial and territorial planning and the implementation of physician-assisted dying.

APPENDICES

Appendix 1 – Member Biographies

DR. JENNIFER GIBSON (CO-CHAIR)

Ontario

Director of the University of Toronto Joint Centre for Bioethics

Jennifer Gibson is Sun Life Financial Chair in Bioethics and Director of the University of Toronto Joint Centre for Bioethics, and Associate Professor in the Institute of Health Policy, Management, and Evaluation at the University of Toronto. She holds a PhD in philosophy (bioethics and political theory). Her research focuses on ethical governance and performance of health organizations and systems. Gibson directs the World Health Organization Collaborating Centre for Bioethics at the University of Toronto and is also a member on the Executive Committee for the Global Institute for Psychosocial, Palliative, and End-of-Life Care, University of Toronto and Princess Margaret Cancer Centre. Jennifer has served on government and health sector advisory committees on public health emergencies, critical care triage, drug funding and supply, and the Ebola response in Ontario and internationally.

MAUREEN TAYLOR (CO-CHAIR)

Ontario

Physician Assistant in Infectious Diseases and Medical Journalist

Maureen Taylor is a Physician Assistant (PA) in Infectious Diseases at Toronto East General Hospital, and an Associate Clinical Professor in the Department of Family Medicine at McMaster University. Prior to her studies as a PA, Maureen was a broadcast journalist for 25 years, including seven years as the National Medical/Health Reporter for the Canadian Broadcasting Corporation. Maureen is a three time winner of the Canadian Medical Association/Canadian Nurses Association awards for excellence in health reporting.

Maureen was married to microbiologist and infectious disease expert Dr. Donald Low, who was diagnosed with an inoperable brain tumour in February 2013. He died seven months later. Since then, Maureen has publicly advocated for the right of terminally ill Canadians to choose an assisted death.

DR. DOUG COCHRANE

British Columbia

Patient Safety and Quality Officer for BC and Chair of the BC Patient Safety and Quality Council

Dr. Doug Cochrane is the Patient Safety and Quality Officer for BC and Chair of the BC Patient Safety and Quality Council. He is also a Professor at the University of British Columbia in Neurosurgery.

The BC Patient Safety & Quality Council has adopted a definition of quality that spans health care. Care at the end-of-life is one sector in which the Council advocates, supporting end-of-life planning, palliation where needed and primary care and home services.

Given the nature of Dr Cochrane's clinical practice as a neurosurgeon, meeting and care for and with families and patients facing end-of-life are common. Arising from this experience, Dr Cochrane recognizes the importance of how a disease process and treatments are affected by the context of the patient and family. Care is not only providing treatments of a disease process or the minimization disability, but when applicable, allaying suffering and respecting patient family autonomy. He has written on the Groningen Protocol.

DR. JOCELYN DOWNIE

Nova Scotia

Professor in the Faculties of Law and Medicine at Dalhousie University

Jocelyn Downie is a Professor in the Faculties of Law and Medicine at Dalhousie University. She is a Fellow of the Pierre Elliott Trudeau Foundation as well as a Fellow of the Royal Society of Canada and the Canadian Academy of Health Sciences. She received an honours BA and MA in Philosophy from Queen's University, an MLitt in Philosophy from the University of Cambridge, an LLB from the University of Toronto, and an LLM and Doctorate in Law from the University of Michigan. After graduation from law school, she clerked for (former) Chief Justice Antonio Lamer at the Supreme Court of Canada.

Specifically in the area of assisted death, Downie has published numerous books and articles including *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*, winner of the 2005 Abbyann Lynch Medal in Bioethics from the Royal Society of Canada. Downie was also a Special Advisor to the Senate of Canada Committee on Euthanasia and Assisted Suicide, a member on the Royal Society of Canada's Expert Panel on End-of-Life Decision Making, and a member of the pro bono legal team in *Carter*.

RUTH GOBA

Ontario

Human Rights Lawyer & Commissioner, Ontario Human Rights Commission

From February to October 2015, Ruth served as the Interim Chief Commissioner of the Ontario Human Rights Commission. She was first appointed as a Commissioner by the Government of Ontario in 2006 and continues in that capacity today.

Ruth received her B.A. (Honours) from the University of Toronto (1996) and her LLB from Osgoode Hall Law School (2000). She was called to the Bar in 2002.

After graduating from law school, Ruth worked in India for an international NGO on women's equality rights and with the United Nations Special Rapporteur on the Right to Adequate Housing. She has appeared before the UN Committee on Economic, Social and Cultural Rights in Geneva, Switzerland and has advocated at the UN Human Settlement Programme (UN HABITAT) in Nairobi, Kenya. In 2001, she completed her articles of clerkship at ARCH Disability Law Centre and then worked for the Centre for Equality Rights in Accommodation (CERA), a human rights organization that works domestically and internationally for equality in housing and for the realization of economic and social rights. From 2007 to 2009, she was the Executive Director of CERA. In private human rights law practice, Ruth's focus was on gender, disability and racial discrimination in employment and education.

Ruth has taught Disability Studies at Ryerson University, served on the Board of the National Association of Women in the Law and on LEAF's Legal Committee.

DR. NUALA KENNY

Nova Scotia

Professor Emeritus Dalhousie University Department of Bioethics

Dr. Nuala Patricia Kenny received her BA, Magna Cum Laude, from Mount Saint Vincent University in 1967, an MD from Dalhousie in 1972 and became a Fellow of the Royal College of Physician and Surgeons of Canada in Paediatrics in 1975. In 1993 she completed a Bioethics Fellowship at the Kennedy Institute of Ethics at Georgetown University.

After a distinguished career in pediatrics at the Hospital for Sick Children, Toronto and Queen's University, Kingston, she returned to Dalhousie as Professor and Head of the Department of Pediatrics and Chief of Pediatrics at the Izaak Walton Killam Hospital in 1988. In 1995, she became the founding Chair of the Department of Bioethics of the Dalhousie Faculty of Medicine.

From February to November 1999, Dr. Kenny was seconded as Deputy Minister of Health for the Province of Nova Scotia. From 2009-2014 she served as Ethics and Health Policy Advisor to the Catholic Health Alliance of Canada.

Past President of both the Canadian Pediatric Society and the Canadian Bioethics Society and author of over one hundred and eighty papers and three books, Dr. Kenny was appointed an Officer of the Order of Canada for her contributions to child health and medical education in 1999. She has received the Lifetime Achievement Award of the Canadian Bioethics Society, the Distinguished Service Award from the Canadian Health Association, the Catholic Health Association of Canada's Performance Citation Award, the Canadian Medical Association's Marsden Ethics Award and the Dalhousie University Alumni Achievement Award.

She has received six Honorary Doctorates for her work in child health, medical education and bioethics from Mount Saint Vincent University, Halifax, the Atlantic School of Theology, Halifax, Regis College,

Toronto, St. Francis Xavier University Antigonish, The College of New Rochelle, New York and Saint Paul's University, Ottawa.

PROFESSOR ARTHUR SCHAFER

Manitoba

Director of the Centre for Professional and Applied Ethics at the University of Manitoba

Arthur Schafer is Director of the Centre for Professional and Applied Ethics, at the University of Manitoba. He is also a Full Professor in the Department of Philosophy and an Ethics Consultant for the Department of Paediatrics and Child Health at the Health Sciences Centre in Winnipeg. For 10 years he was Head of the Section of Bio-Medical Ethics in the Faculty of Medicine of the University of Manitoba. He has also served as Visiting Scholar at Green College, Oxford.

Schafer has received a number of awards and honours. He is a Canadian Commonwealth Scholar, Honorary Woodrow Wilson Scholar, and a Canada Council Fellow. At the University of Manitoba he has received the Stanton Teaching Excellence Award, the Campbell Award for University Outreach, and the University Teaching Service Award for Teaching Excellence. He has published widely in the fields of moral, social, and political philosophy. He is author of *The Buck Stops Here: Reflections on moral responsibility, democratic accountability and military values*, and co-editor of *Ethics and Animal Experimentation*. He has published over 90 scholarly articles and book chapters, covering a wide range of topics, with a special focus on issues in professional and bio-medical ethics, business and environmental ethics. Schafer is National Research Associate of the Canadian Centre for Policy Alternatives, which has published two of his reports. He has made several hundred conference presentations in Canada and abroad, and has written dozens of newspaper articles for *The Globe and Mail*, *The Toronto Star*, *The Winnipeg Free Press*, *The Medical Post*, and *The Sunday Times (London)*.

DR. TREVOR THEMAN

Alberta

Registrar of the College of Physicians and Surgeons of Alberta

Dr. Trevor Theman is the Registrar of the College of Physicians and Surgeons of Alberta (CPSA), the regulatory body of the practice of medicine in Alberta. The CPSA provides direction to members on ethics and other issues such as physician-assisted dying. Dr. Theman is the former president of the Federation of Medical Regulatory Authorities of Canada (FMRAC). FMRAC is the national voice of the medical regulatory authorities in Canada.

DR. KARIMA VELJI

Ontario

President of the Canadian Nurses Association and Integrated Vice President, Mental Health Services, for London Health Science Centre and St. Joseph's Health Care London

Dr. Karima Velji is the 46th President of the Canadian Nurses Association. She is the integrated vice-president for mental health at London Health Sciences Centre and St. Joseph's Health Care. Most recently, Dr. Velji was the chief operating officer and chief nursing executive at Baycrest, a global leader in innovations on aging and brain health, and was vice-president of patient care and chief nursing executive at the Toronto Rehabilitation Institute, now a program in the University Health Network.

She has led the development of patient experience projects for the Ministry of Health and Long-Term Care and Local Health Integration Networks in Ontario. She has also led external reviews of several organizations including the Sunnybrook Health Sciences Centre, Bruyère Continuing Care and Schlegel Villages. In addition, she is board vice-chair with Accreditation Canada.

Dr. Velji has been a senior leader of palliative care services within her organizational leadership roles. She has clinical background as an oncology and palliative care nurse.

Appendix 2 – List of Stakeholders Consulted

Written Stakeholder Submissions Received

- ARCH Disability Law Centre
- Association for Reformed Political Action Canada
- Association of Registered Nurses of Newfoundland and Labrador
- BC Civil Liberties Association
- Canadian Association for Community Living
- Canadian Bar Association
- Canadian Civil Liberties Association
- Canadian Council of Registered Nurse Regulators
- Canadian Federation of Catholic Physicians' Societies
- Canadian HIV/AIDS Legal Network
- Canadian Hospice Palliative Care Association
- Canadian Medical Association
- Canadian Medical Protective Association (CMPA)
- Canadian Nurses Association
- Canadian Partnership Against Cancer
- Canadian Society of Hospital Pharmacists
- Canadian Society of Palliative Care Physicians
- Canadian Society of Respiratory Therapists
- Canadian Unitarian Council
- Canadian Working Group on HIV and Rehabilitation
- Catholic Civil Rights League
- Catholic Health Alliance of Canada
- Catholic Health Corporation of Manitoba
- Centre for Israel and Jewish Affairs
- Centres for Addiction and Mental Health
- Christian Legal Fellowship
- Citizens with Disabilities Ontario
- College of Family Physicians Canada
- College of Pharmacists of Manitoba
- College of Physicians and Surgeons of Manitoba
- College of Physicians and Surgeons of Ontario
- College of Registered Nurses of Manitoba
- College of Registered Nurses of Nova Scotia
- Council of Canadians with Disabilities
- Covenant Health
- Doctors NS
- Dying With Dignity
- Evangelical Fellowship of Canada
- Health Quality Council of Alberta
- HIV & AIDS Legal Clinic Ontario
- Hospice Palliative Care Ontario

- Human Rights Watch
- Manitoba Multi-faith Council
- Mental Health Commission of Canada
- National Association of Pharmacy Regulatory Authorities
- Northern Health Region
- NWT Medical Association
- Ontario Hospital Association
- Ontario Medical Association
- Palliative Manitoba
- Patients Canada
- PEI College of Physicians and Surgeons
- Physicians' Alliance against Euthanasia
- Protection of Conscience Project
- Public Prosecutions New Brunswick
- Qikiqtani Medical Association
- Saskatchewan Association of Social Workers (SASW)
- Winnipeg Regional Health Authority

In-Person/Teleconference Consultations

- Association of Faculties of Medicine of Canada
- BC Civil Liberties Association
- Canadian Association for Community Living
- Canadian Association of Retired Persons
- Canadian Cancer Society
- Canadian Civil Liberties Association
- Canadian Council of Registered Nurse Regulators
- Canadian Hospice Palliative Care Association
- Canadian Life and Health Insurance Association
- Canadian Medical Association
- Canadian Medical Protective Association
- Canadian Psychiatric Association
- Canadian Society of Palliative Care Physicians
- Council of Canadians with Disabilities
- Council of Pharmacy Registrars of Canada
- Covenant Health
- Dying With Dignity
- Ontario Hospital Association
- David Zussman, Jarislowsky Chair on Management in the Public Sector, University of Ottawa
- Dr. James Downar, palliative care physician
- Dr. Eric Wasylenko, palliative care physician
- Mr. David Wright, palliative care nurse
- Dr. Paul Henteleff, palliative care physician
- Dr. Gary Rodin, psychosocial oncology and palliative care physician

Appendix 3 – Recommendations That Should Be Implemented Through Provincial/Territorial Legislation

Recommendation 3: All provinces and territories should ensure access to physician-assisted dying, including both physician-administered and self-administered physician-assisted dying. The recommendations set out in Appendix 3 should be implemented through provincial/territorial legislation.

Recommendation 4: Provinces and territories should require all regional health authorities to have an effective publicly-funded care coordination system in place to ensure patient access to physician-assisted dying.

Recommendation 5: Provincial/territorial governments should publicly fund physician-assisted dying.

Recommendation 9: Provinces and territories should ensure that health professionals are protected from liability for acts or omissions done in good faith and without negligence in providing or intending to provide physician-assisted dying.

Recommendation 11: Provinces and territories should establish requirements to ensure a patient declaration form is completed and witnessed by an independent party.

Recommendation 14: Substitute decision makers should not be given the legal authority to consent to/authorize physician-assisted dying on behalf of an incompetent patient.

Recommendation 15: Provinces and territories should create a patient information form that gathers demographic data on those requesting physician-assisted dying and the reasons for the request.

Recommendation 16: To support case review and system oversight, data should be collected from the patient's initial request to the time of signing the death certificate and/or the completion of that patient's request (e.g., patient withdrawal of request, physician denial of requests).

Recommendation 18: "Grievous and irremediable medical condition" should be defined as a very severe or serious illness, disease or disability that cannot be alleviated by any means acceptable to the patient. Specific medical conditions that qualify as "grievous and irremediable" should not be delineated in legislation or regulation.

Recommendation 21: Access to physician-assisted dying should be available only to those who are eligible for publicly-funded health services.

Recommendation 22: Two physicians must assess the patient to ensure that all criteria are met.

Recommendation 29: Following the provision of physician-assisted dying, physicians should file a report with a Review Committee to support the review of each individual case. This review will ensure transparency and confirm compliance with existing policies and procedures.

Recommendation 30: Physician-assisted dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for physician-assisted dying should be listed as the cause of death.

Recommendation 31: Conscientiously objecting health care providers should be required to inform patients of all end-of-life options, including physician-assisted dying, regardless of their personal beliefs. (**See Note Below*)

Recommendation 32: Conscientiously objecting health care providers should be required to appropriately inform their patients of the fact and implications of their conscientious objection to physician-assisted dying. Any ongoing treatment of the patient must be provided in a non-discriminatory manner. (**See Note Below*)

Recommendation 33: Conscientiously objecting health care providers should be required to either provide a referral or a direct transfer of care to another health care provider or to contact a third party and transfer the patient's records through the system described in Recommendation 4. (**See Note Below*)

Recommendation 34: All institutions should be required to inform patients/residents of any institutional position on physician-assisted dying, including any and all limits on its provision.

Recommendation 35: Provinces and territories should prohibit any requirement by institutions that patients give up the right to access physician-assisted dying as a condition of admission.

Recommendation 36: Provinces and territories should prohibit any requirement by institutions that physicians refrain from the provision of physician-assisted dying external to the non-participating institution. In addition, employment conditions or privileges should not be negatively impacted in any way.

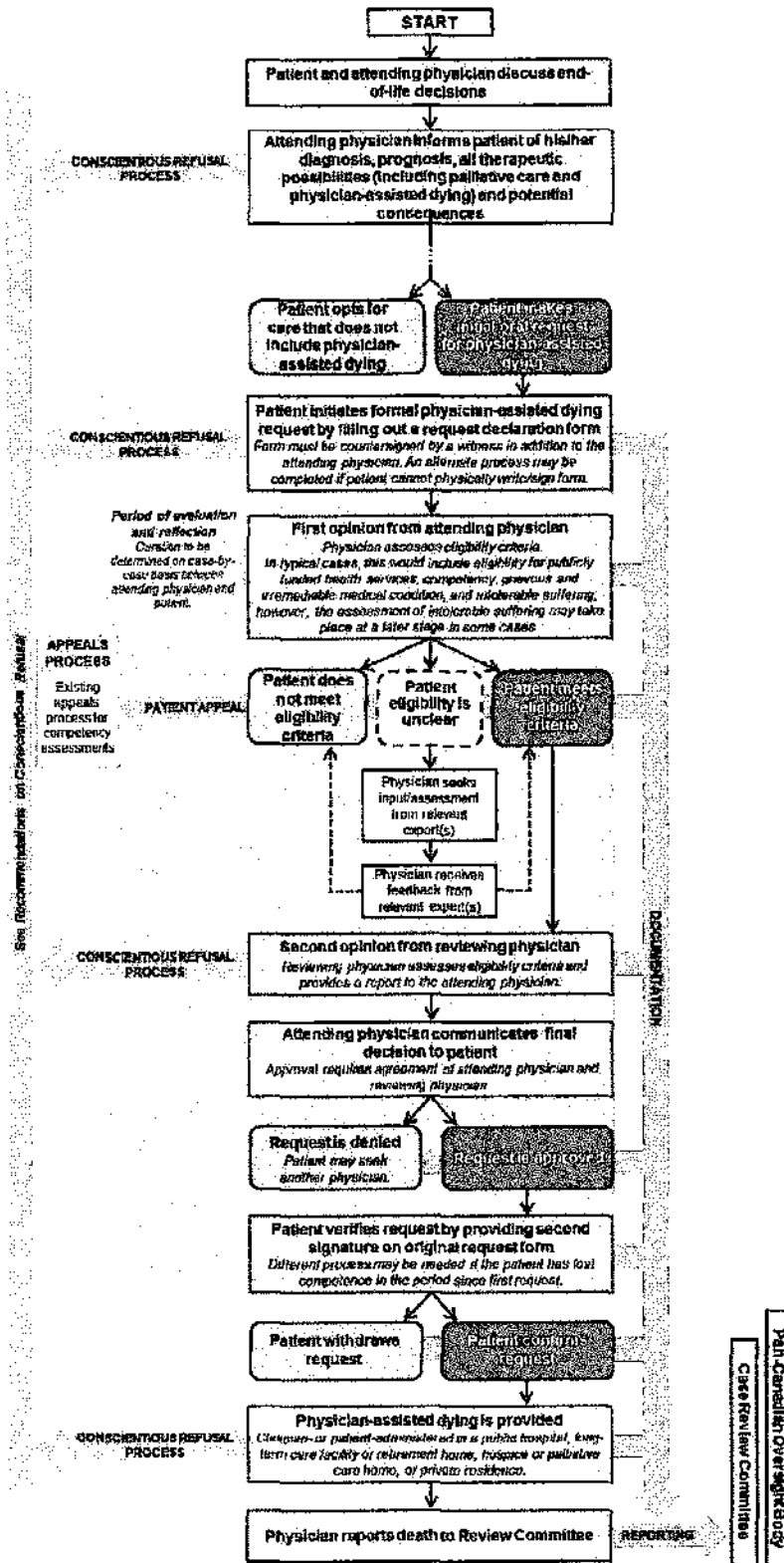
Recommendation 37: Non faith-based institutions, whether publicly- or privately-funded, must not prevent physician-assisted dying from being provided at their facilities.

Recommendation 38: Faith-based institutions must either allow physician-assisted dying within the institution or make arrangements for the safe and timely transfer of the patient to a non-objecting institution for assessment and potentially, provision of physician-assisted dying. The duty of care must be continuous and non-discriminatory.

Recommendation 39: Provincial and territorial governments should establish Review Committee systems to review all cases of physician-assisted dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.

Note: All members of the Advisory Group agreed with the duties set out in these recommendations, but one member believes that they should be implemented through professional regulatory authority standards rather than legislation.

Appendix 4 – Patient Pathway



Cover art designed by Freepik

Page 0617 to/à Page 0641

Withheld pursuant to/removed as

s.13,s.16

Page 0642 to/à Page 0703

Withheld pursuant to/removed as

s.16

Scheffel, Emile HLTH:EX

From: Badger, Derek [JOICA] <dbadger@its.jnj.com>
Sent: Tuesday, January 12, 2016 4:56 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Follow Up Flag: Follow up
Flag Status: Completed

Let me know if you and Derek (good name) might have a few moments to connect. It would be good to update you both on a few things. I will be at a company meeting up the street. After hours works just as well if you are staying over on the Monday, Tuesday or Wednesday.

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:49 PM
To: Badger, Derek [JOICA]
Subject: RE: Janssen (J&J) Letter to Minister Lake

Derek Robertson (EA) and I will both be there.

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jnj.com>]
Sent: Tuesday, January 12, 2016 4:48 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

OK, thanks.

Do you know who from your office will be accompanying the Minister at the FPT meetings next week?

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Badger, Derek [JOICA]
Subject: RE: Janssen (J&J) Letter to Minister Lake

I would love to know! No intel just yet.

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jnj.com>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks Emile, that would be great if you could connect me with the new CoS and MA when they are in place.

Do you know when they might be in place? Anyone I might already know from another Minister's office?

Appreciate your help with this.

Derek

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:16 PM
To: Badger, Derek [JOICA]; Merrifield, Katy PREM:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Best,

E

From: Badger, Derek [JOICA] [mailto:dbadger@its.jnj.com]
Sent: Tuesday, January 12, 2016 4:09 PM
To: Merrifield, Katy PREM:EX; Scheffel, Emile HLTH:EX
Subject: Janssen (J&J) Letter to Minister Lake

Hi Katy and Emile,

Happy New Year – I hope you are both doing well.

As an FYI, I just wanted to share a letter that has been sent from my President to Minister Lake, sharing our position on National Pharmacare in advance of next week's Health FPT meetings in Vancouver. Let me know if you have any questions or concerns – happy to discuss at your convenience.

Will either of you be attending the Health FPT meetings next week? I will be in Vancouver and would love the opportunity to briefly bring you up-to-speed on the status of our 'Biologics Portfolio Proposal' that we discussed back in October. Let me know if that might work – if not, perhaps we can find a few minutes over the phone sometime soon.

Thanks so much,

Derek Badger
Manager, Government Affairs and Policy
Office: 250.770.1600
Mobile: 250.486.0194



Scheffel, Emile HLTH:EX

From: Rattan, Jasminder <Jasminder.Rattan@leg.bc.ca>
Sent: Tuesday, January 12, 2016 4:53 PM
Subject: Opposition Watch: Jan 12/16

Jan 12/16

Bold: Signifies an event added since last distribution

Red: Signifies person of note attending/speaking

Jan 11

- Federal Greens: Elizabeth May, Sidney-North Saanich Town Hall, Jan 11/16 @ 7PM – 8:30PM, Bodine Hall, Mary Winspear Centre, 2243 Beacon Avenue, Sidney.

Jan 12

- Federal Greens: Elizabeth May, Central Saanich Town Hall, Jan 12/16 @ 7PM – 8:30PM, Cedar Room, Saanich Fairgrounds, 1528 Stellys X Road, Saanichton.

Jan 13

- Federal Greens: Elizabeth May, Pender Island Town Hall, Jan 13/16 @ 5:30PM – 7PM, Pender Island Community Hall, 4418 Bedwell Harbour Road, Pender Island.
- BCNDP: Melanie Mark (candidate), Walk the Talk Wednesday, Jan 13/16 @ 5PM – 8PM, 1303 Commercial Drive, Vancouver.
- BCNDP: Scott Fraser, Alberni Connect – Hosted by the Young Professionals of Alberni Valley, Jan 13/16 @ 6PM – 8PM, Char's Landing, 4815 Argyle Street, Port Alberni.

Jan 14

- Federal Greens: Elizabeth May, Mayne Island Town Hall, Jan 14/16 @ 6PM – 7:30PM, Mayne Island Community Centre, 493 Felix Jack Road, Mayne Island.

Jan 15

- Federal Greens: Elizabeth May, Saturna Island Town Hall, Jan 15/16 @ 6PM – 7:30PM, Saturna Community Hall, 109 East Point Road, Saturna Island.

Jan 16

- BCNDP: Jodie Wickens (candidate), Super Saturday Canvass Blitz, Jan 16/16 @ 11AM, 2565 Barnet Highway, Coquitlam.
- BCNDP: Melanie Mark (candidate), Social Justice Saturday, Jan 16/16 @ 10AM, 1303 Commercial Drive, Vancouver.

Jan 17

- BCNDP: John Horgan and Melanie Mark (candidate), Sunday Dim Sun with Melanie Mark and John Horgan, Jan 17/16 @ 10AM, Pink Pearl Chinese Restaurant, 1132 East Hastings Street, Vancouver.
- BCNDP: David Eby, A Home for Everyone, Jan 17/16 @ 7PM, Creekside Commons Co-housing, 2202 Lambert Drive, Courtenay.

Jan 19

- BCNDP: Selina Robinson, Community Refugee Resettlement Forum – How You Can Help, Jan 19/16 @ 7:30PM, Coquitlam Royal Canadian Legion, 1025 Ridgeway, Coquitlam.

Jan 21

- BCNDP: David Eby and Carole James, Public Discussion on Tenancy Laws and Evictions, Jan 21/16 @ 4PM, Venue TBD.

Feb 06

- BCNDP: Selina Robinson, Love Your Body Summit, Feb 06/16 @ 9AM – 4PM, Inlet Theatre, 100 Newport Drive, Port Moody.

Feb 13

- BCNDP: John Horgan, 8th Annual Sweetheart of an Evening – Fundraising Dinner and Auction hosted by the Juan de Fuca New Democrats, Feb 13/16 @ 7PM, Olympic View Golf Course, 643 Latoria Road, Victoria.

Feb 20

- BCNDP: Bruce Ralston, Coldest Night of the Year – Fun Walk Fundraiser, Feb 20/16 @ 4PM – 8PM, Surrey Urban Mission Society, 10776 King George Blvd, Surrey.

Mar 04

- BCNDP: Selina Robinson, Maillardville Music Festival, Mar 04/16 @ 7PM, Mackin Park, 1046 Burnette Ave, Coquitlam

Mar 06

- BCNDP: Sue Hammell and Judy Darcy, 11th Annual Kick Up Your Heels, Mar 06/16 @ 10:30AM – 2PM, Aria Banquet Hall, 12350 Patullo Place, Surrey.

Scheffel, Emile HLTH:EX

From: Poillievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 5:03 PM
To: Scheffel, Emile HLTH:EX
Cc: Marr, Ann HLTH:EX
Subject: Health Ministers' Meeting Materials
Attachments: DRAFT At A Glance Agenda - Jan 12.pdf; Conference Information e-Binder_Draft Jan 12.pdf; PT HMM eBinder_draft Jan 12.pdf

Hi Emile,

Please find attached the following materials for the Minister in preparation for the Thursday briefing:

- At a Glance Agenda
- Conference Information e-binder (this includes the itinerary)
- Jan 20 – PT HMM e-binder

Health Canada has just sent out the full package of briefing documents, so we will send a binder for the FPT day early tomorrow. We have requested materials on the separate meetings the Minister is attending (CFNU, CMA, e-cigarettes) and will add those to the e-binders as soon as they are received.

For the e-binders, he can navigate through the documents using bookmarks. We're also happy to pull out individual documents separately, if he prefers. If you have any questions, please let me know.

Thanks!

Tricia Poillievre

A/Director | Intergovernmental Relations | Ministry of Health, BC
Office: 250 952-1304 | Cell: 250 415-2639 | tricia.poillievre@gov.bc.ca

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:27 PM
To: Scheffel, Emile HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Re: As discussed - Hospice Funding

This is not presented as a decision note. Am I being asked to approve the proposed designation of funds or just being made aware of it?

Terry Lake DVM
Minister of Health

On Jan 12, 2016, at 11:46 AM, "Scheffel, Emile HLTH:EX" <Emile.Scheffel@gov.bc.ca> wrote:

Minister,

Please see attached BN regarding Centre for Palliative Care. It's on your iPad under Approval > BNs for Decision.

Please let us know if you would like a briefing. Comms advises we could announce in February.

Thanks E

<1042945 - Funding to Support the Commitment to Double Hospice Spaces.docx>

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:23 PM
To: McCormick, Erika HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Re: BC Fentanyl Overdose Response and EMA Regulation change

I already signed this order. Please confirm.

Terry Lake DVM
Minister of Health

> On Jan 12, 2016, at 4:07 PM, "McCormick, Erika HLTH:EX" <Erika.McCormick@gov.bc.ca> wrote:
>
> Hi Minister,
>
> The attached are on the iPad under:
>
> Approval --> Briefing Notes for Decision --> BC Fentanyl Overdose
> Response and EMA Regulation
>
> Thanks,
>
> Erika McCormick,
> Administrative Assistant to the Honourable Terry Lake Minister of
> Health
> Email: Hlth.minister@gov.bc.ca/ Phone: 2509533547 PO Box 9050 Stn Prov
> Govt Victoria BC V8W 9E2
>
>
> <1044900 IBN - BC Fentanyl Overdose Response.doc>
> <1044900 Appendix B.docx>
> <1046754 EMA Regulation Package Administer Nalaxone.pdf>

Scheffel, Emile HLTH:EX

From: MyHR <myhr@gov.bc.ca>
Sent: Tuesday, January 12, 2016 5:19 PM
To: Scheffel, Emile HLTH:EX
Subject: s.22

Thank you for contacting the BC Public Service Agency. Your request has been received and is summarized below.

We are currently experiencing higher than normal request volumes, we appreciate your patience. Please do not send in multiple requests relating to the same query, as it can slow down response time.

Visit [AskMyHR](#) to create, update or track your service requests.

BC Public Service Agency

[AskMyHR](#)

MyHR 250.952.6000 | Toll Free 1.877.277.0772

Service Request Summary

Hi there,

s.22

Many thanks in advance!

Emile

Page 0712 to/à Page 0717

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s.16

Page 0718 to/à Page 0816

Withheld pursuant to/removed as

s.13,s.16

Crisis



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20492



CIFR IRSC
CENTRE FOR INTERNATIONAL PROGRAMS
IN RESEARCH AND SERVICES

Together, we can do this

Strategies to Address British Columbia's Prescription Opioid Crisis

Recommendations from the British Columbia Node of
the Canadian Research Initiative on Substance Misuse

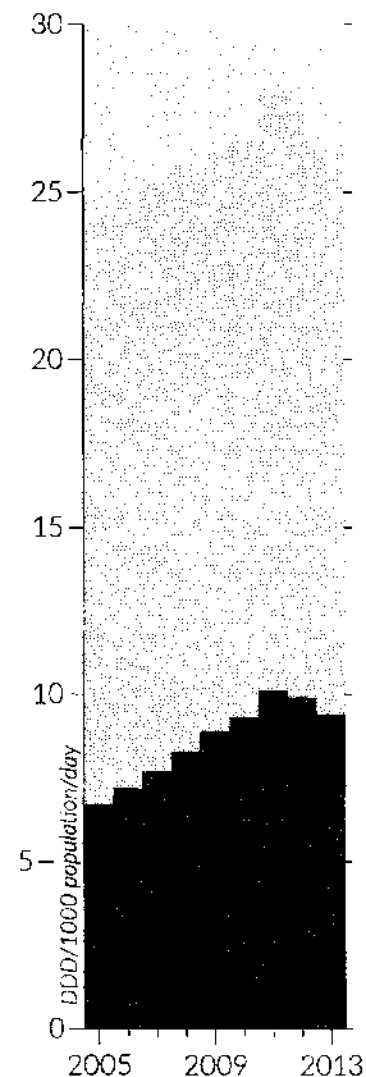
Executive summary

Recent events in British Columbia have highlighted the urgency with which policy makers, regulatory bodies and clinicians need to act together to address the public health harms related to pharmaceutical opioids and other addictive pharmaceutical drugs. This report briefly describes the provincial pharmaceutical opioid problem and provides several key recommendations for immediate steps to reduce fatal overdoses, misuse, addiction and other severe harms related to unsafe opioid prescribing in BC.

fig 1
Annual opioid dispensing
(not including methadone)
in BC, 2005–2013

Weak opioids
Strong opioids

Fischer et al., 2014.
* DDD = defined daily dose



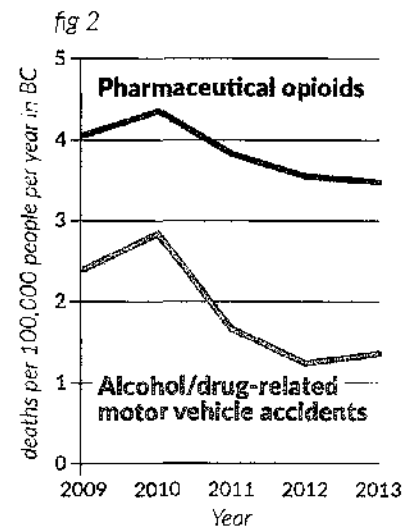
The prescription opioid epidemic

Canada has the second highest opioid consumption rate among developed countries, with the rate of pharmaceutical opioid use tripling in Canada over the past decade.¹⁻³ Despite similar rates of chronic pain across Canada, there is substantial variation in the rates and types of opioids prescribed across provinces.⁴⁻⁸ For example, British Columbia (BC) dispenses more than double the amount of opioids compared to Quebec, the lowest opioid dispensing province.^{6,8} Additionally, from 2005 to 2011, the rate of dispensing strong opioids in BC increased by almost 50% overall, including a 135% increase in oxycodone dispensation.⁶ Notably, these increases in opioid prescribing conflict with the increasing body of research suggesting that opioids may have limited long-term effectiveness for treating chronic non-cancer pain, and that the risk profile of opioids may outweigh their potential short-term benefits in cases of mild to moderate acute pain.^{9, 11}

In addition to an increased rate of opioid prescribing, there is evidence of inappropriate and high-risk opioid prescribing practices in BC. For instance, while patients on methadone commonly have chronic pain, past research suggests that 35% of patients on methadone maintenance treatment in BC are co-prescribed opioids that are often not prescribed by the patient's primary methadone provider.¹² This is problematic since co-prescriptions with methadone have important safety considerations, as evidenced by a recent study of provincial mortality data found that methadone was involved in 25% of pharmaceutical opioid-related deaths in BC.¹³ Equally concerning are the persistently high rates of benzodiazepine prescribing in BC,¹⁴ given that co-prescription of benzodiazepines and opioids has long been known to be a major risk factor for fatal overdose.¹⁵⁻¹⁸

Coinciding with the dramatic increases in opioid prescribing in BC, there are high rates of opioid dependence, addiction and misuse that have contributed to significant health and social harms. In 2013, there were more than 330 deaths in BC related to illegal drug overdose including opioids. Of these deaths, 87% were accidental.¹⁹ Pharmaceutical opioids account for a large proportion of these deaths, to the extent that the number of pharmaceutical opioid-related deaths exceeds the number of deaths from motor vehicle accidents involving alcohol in BC (Figure 2).^{13,19-21} Furthermore, among the pharmaceutical opioid-related deaths in BC, 93% involved at least one other high-risk medication (e.g., benzodiazepines).²¹ Although rates of prescription opioid-related death in BC have plateaued in recent years, the province is still experiencing annual mortality rates of close to 4 deaths per 100,000 people.¹³

Studies have suggested that approximately 40% of prescribed pharmaceutical opioid-related deaths occur among people who are prescribed opioids above recommended safe-dosing guidelines.²² Furthermore, deaths related to prescribed pharmaceutical opioids correlate strongly with rates of opioid dispensation in BC.²³ In addition to opioid overdose and mortality,²⁴ there are extensive health and social harms associated with pharmaceutical opioids, including injuries and trauma;²⁵ increased risk of costly emergency department visits;^{26,27} diversion to street-based markets, drug dealing and other



More people die in BC each year from pharmaceutical opioids (including methadone) than from alcohol/drug-related motor vehicle accidents.^{13,19-21}

addiction-associated petty crime.^{3,28} Additionally concerning is evidence highlighting the growing number of infants being born with opioid addiction in Canada.²⁹ Finally, recent evidence has demonstrated that many individuals who initially used pharmaceutical opioids or benzodiazepines illicitly may eventually transition to heroin or intravenous drug use thus substantially increasing the risk for blood-borne infections and overdose.³⁰⁻³⁶

In the face of this evidence, change has been slow to come. This brief paper was prepared through

the secretariat of the British Columbia node of the CIHR Canadian Research Initiative on Substance Misuse (CRISM). The development of this document included a range of expert stakeholders through the network's membership and other experts (Appendix A). This urgent call to action outlines changes that can be immediately implemented in BC to substantially reduce the rates of overdose death, addiction and related harms that stem directly from the current system.

Urgent need for action in British Columbia

While the pharmaceutical opioid epidemic has emerged throughout North America, recent events in BC have highlighted the urgency with which BC policy makers must act to address the public health harms related to pharmaceutical opioids and other addictive pharmaceutical drugs. Despite the scale of the present public health problem, strategies to meaningfully address unsafe prescribing have not been implemented. This is despite the fact that, ultimately, prescribers are largely responsible for the burgeoning illicit market in pharmaceutical opioids that has developed on the streets of BC.³⁷⁻⁴⁰ In fact, the entry of organized crime groups into the manufacturing of counterfeit pharmaceutical opioids (which often contain fentanyl) to fuel the street market for illicit or diverted opioids is arguably a direct result of longstanding unsafe physician prescribing practices.⁴¹⁻⁴³

Specifically, BC has witnessed a spike in fentanyl related overdoses and deaths. Within only two years, there has been a seven-fold increase in fentanyl detected deaths in BC (from 13 deaths in 2012 to 90 deaths in 2014), representing 25% of all illicit drug related deaths in the province in 2014.^{44,45} In 2015, there have been several high profile deaths from fentanyl in BC,⁴⁶⁻⁴⁸ as well as 16 cases of suspected fentanyl overdoses in a single day in Vancouver.⁴⁹⁻⁵¹ This worsening of the situation has occurred despite focused drug-law enforcement on the illicit fentanyl trade that has included at least 11 search warrants, 8 charges and 500,000 pills

seized in Metro Vancouver alone.^{41,52,53} Based on past evidence regarding the limited effectiveness of police seizures on controlling the availability of illicit drugs, it is unlikely that law enforcement efforts are a promising solution to this problem.^{54,55}

In 2015, sixteen cases of suspected fentanyl overdoses were once reported in a single day in Vancouver.

Equally concerning are the persistently high prescribing rates of benzodiazepines in BC. Benzodiazepines are sedating hypnotic medications that, despite limited evidence of effectiveness and clear evidence of harms (e.g., addiction, fatal overdose, etc.), continue to be regularly used to treat sleep disorders and other minor health conditions for which there are much safer alternatives. In fact, benzodiazepines remain among the most commonly prescribed and misused types of psychoactive drug in the world, despite their link to serious harms, including cognitive impairment and decline (i.e., dementia), accidents and injuries, dependence and addiction, and fatal overdose — especially when used in combination with opioids or alcohol.⁵⁶⁻⁵⁸ Locally, recent research has found that benzodiazepine use

was associated with elevated rates of HIV infection among a cohort of people who inject drugs, and addiction to benzodiazepines is known to be extremely difficult to treat.⁵⁹ In light of these risks, many clinical guidelines now recommend against prescribing benzodiazepines, yet inappropriate prescribing has continued to persist in BC.¹⁴ As a result, the percentage of pharmaceutical opioid related overdose deaths involving benzodiazepines in BC increased 600% between 2004 and 2013.¹³

Areas for intervention

In the wake of the crisis that exists in BC, there has yet to be sufficient action from various colleges (i.e., College of Physicians and Surgeons of BC, College of Pharmacists of BC, College of Registered Nurses of BC, College of Dental Surgeons of BC, College of Veterinarians of BC) or other regulatory bodies across the province. This situation is likely a result of these groups waiting on Health Canada for action, coupled with the fact that no single group (e.g., regulatory bodies, police, etc.) has a clear mandate to address the current epidemic.

Fortunately, BC is uniquely positioned to rapidly implement several safeguards to reduce unsafe prescribing practices through the province's PharmaNet system and other interventions. PharmaNet is an electronic information system that records data (e.g., drug name, dose, quantity, duration, prescribing practitioner, dispensing pharmacy) on all prescriptions dispensed at community pharmacies in BC.⁶⁰ Previous research has suggested that the real-time, centralized nature of PharmaNet, which allows prescribers and pharmacists to access patients' current prescription information, can be effective in reducing inappropriate prescriptions of opioids and benzodiazepines by approximately 30-50%.⁶¹ Notably, this study was performed at a time when only pharmacies had access to PharmaNet, suggesting that there is room for even greater reduction of inappropriate prescribing if PharmaNet is more widely utilized by prescribers and pharmacies. To this end, enabling physicians and nurse practitioners to access patients' opioid

prescription history promotes optimal opioid prescribing practices.⁶²

However, presently, physicians and nurse practitioners in BC are able—but not required—to use PharmaNet when prescribing medications. Here, it is estimated that less than 30% of physicians in BC have enrolled for PharmaNet,⁶² which means that over 70% of BC physicians may be writing opioid prescriptions without knowing if the patient in front of them is already prescribed opioids from multiple other practitioners. This is a very real concern, as evidenced by the case of one BC resident who received more than 23,000 pills of oxycodone from more than 50 physicians and 100 pharmacies over five years.⁶⁴

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Additionally, practitioners who do not use PharmaNet may be unaware if a patient is receiving medications that pose high risk for overdose if co-prescribed with opioids, such as benzodiazepines or methadone. Furthermore, it is not currently required that benzodiazepines are prescribed on a duplicate prescription pad, which is an additional safeguard that is in place for opioids and other medications that pose high risk for misuse, diversion or overdose.⁶⁵ Prescription monitoring for benzodiazepines has already been enacted in other settings including Alberta and New York.^{66,67} A study of the New York triplicate prescription program found that benzodiazepine prescribing was reduced by nearly 50% after the program's implementation. These reductions were sustained for at least seven years after the program's implementation, and most

patients did not require supplemental medication once their benzodiazepine prescriptions were discontinued.⁶⁷

In addition to clinic-level prescribing practices, due to common pain and injury presentations, emergency departments can be another source of opioids. One study conducted at Vancouver General Hospital found that patients who were prescribed opioids upon discharge from the emergency department had triple the odds of experiencing an adverse event within two weeks.⁶⁸ Given the demands placed on emergency department staff for providing pain relief among injured and other patients who present to emergency rooms, research and educational interventions tailored to emergency department settings—such as clinical guidelines, electronic decision support tools, and clinician education—require resources to support opportunities for safer opioid prescribing in this environment.

In the absence of the above safeguards, some limitations of Canadian prescribers should be noted. For instance, physicians in BC have traditionally

received little training on how to safely prescribe opioids or how to identify and treat opioid addiction. In fact, only one third of Canadian universities provide mandatory instruction in pain management as part of undergraduate medical training. Not surprisingly, it has been estimated that only approximately 30% of Canadian family physicians feel strongly confident in their opioid prescribing skills.^{69,70} Furthermore, primary care physicians have demonstrated high rates of continuing ineffective opioid prescriptions, being unaware of opioid monitoring guidelines and demonstrating low levels of knowledge regarding safe opioid prescribing in the context of chronic pain treatment.⁶⁹ Similarly, previous studies have found that up to 94% of primary care physicians may be unable to identify symptoms or methods of problematic substance use.⁷¹⁻⁷³ Recommendations regarding the need for greater investment in prescriber education (including nurse practitioners and other prescribers) in addiction and pain management, including the role of non-opioid analgesics for pain management, are described on the next page.

Recommendations

In light of the evidence and the unique characteristics of the system of care in BC, a number of steps should immediately be taken to reduce the harms of the pharmaceutical opioid epidemic in British Columbia. These steps include:

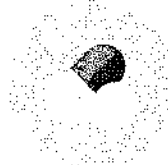
STRATEGIES FOR IMPROVED PRESCRIBING PRACTICES

1. Make registration for PharmaNet free, and legally require all clinicians with prescribing authority to be registered for PharmaNet and routinely check patients' PharmaNet profiles when writing prescriptions. Exemptions to this requirement could be provided for individuals who practice in areas without Internet access or with other barriers.
2. Revise duplicate prescription pads to include a checkbox indicating that the prescribing practitioner has fulfilled his or her legal responsibility to review a patient's PharmaNet record, thereby ruling out duplicate or high-risk co-prescriptions. 
3. Put in place enforcement measures to ensure that pharmacies are checking PharmaNet to confirm that duplicate prescriptions or other evidence of inappropriate medical care is further brought to the attention of prescribing practitioners and regulatory authorities.
4. Change requirements for benzodiazepine prescribing such that benzodiazepines require a prescription on a duplicate prescription pad, in the same way that opioid prescriptions must be written in BC.^{65,67}
5. Implement a maximum upper dispense limit for the amount of opioids that a patient may be dispensed at any one time.

STRATEGIES TO IMPROVE OPIOID ADDICTION CARE

6. Dedicate investments into addiction treatment. For instance, buprenorphine/naloxone—a proven treatment for opioid addiction—should be the first line pharmacotherapy option (along with methadone) for opioid addiction, given its superior safety profile with respect to overdose risk compared to methadone.⁷⁴⁻⁷⁷

7. Improve access to buprenorphine/naloxone by eliminating the requirement that prescribers must have methadone exemptions in order to prescribe buprenorphine/naloxone.



This requirement is unnecessary given the low misuse potential of buprenorphine/naloxone and the low number of buprenorphine/naloxone prescribers the exemption requirement creates.⁷⁸ In lieu of the methadone exemption, prescribers would be

required to complete an online training module on buprenorphine/naloxone prescribing.

8. Invest in recovery-oriented care for individuals with opioid addiction.
9. Consider comprehensive patient education with regards to risks of poly-substance use and overdose prevention, recognition and response including take home naloxone prescription.^{79,80}
10. Increase prescribers' capacity for opioid agonist treatments (e.g., methadone and buprenorphine/naloxone) via novel collaborative strategies.

LONG-TERM STRATEGIES TO IMPROVE PRESCRIBER KNOWLEDGE

11. Invest in BC's medical curricula and continuing medical education for physicians, nurses and other clinicians in addiction diagnosis, treatment and



recovery; pain management including the use of non-opioid analgesics; and safe opioid prescribing, including the potential for serious adverse effects when opioids are co-prescribed with benzodiazepines and other psychotropic medications.^{78,81}

12. Coinciding with benzodiazepines transitioning to a duplicate prescription requirement, investment should be made in education for BC prescribers on the known serious harms and clinical limitations of benzodiazepines, as well as the availability of safer alternatives.⁸²
13. Support research and educational interventions in emergency departments to enhance safer opioid prescribing practices in this setting.⁸³⁻⁸⁶

If these evidence-based recommendations are enacted quickly, BC has the potential to dramatically reduce fatal overdoses, abuse, addiction and other severe harms related to unsafe opioid prescribing.

Together, we can do this. The time for action is now.

Appendix A: Contributors and endorsers

1. **Keith Ahamad, MD, CCFP, CISAM**
Family and Addiction Medicine Physician,
Providence Health Care / Vancouver Coastal Health
Research Scientist, B.C. Centre for Excellence in
HIV/AIDS
Clinical Assistant Professor, Faculty of Medicine,
UBC
2. **Sandra Allison, MPH, CCFP, FRCPC**
Chief Medical Health Officer, Northern Health
Adjunct Professor, School of Health Sciences,
UNBC
Clinical Assistant Professor, School of Population
and Public Health, UBC
3. **Cecilia Benoit, PhD**
Fellow, Royal Society of Canada
Fellow, Canadian Academy of Health Sciences
Scientist, Centre for Addictions Research of B.C.
Professor, Department of Sociology, University of
Victoria
4. **Neal Berger**
Executive Director, Cedars at Cobble Hill
Addiction Treatment Centre
5. **James I. Brooks, MD, FRCPC**
Medical Director, Communicable Disease
Prevention and Control Service
British Columbia Centre for Disease Control
6. **Bill Bullock, MD, CCFP**
Family and Addiction Medicine Physician, Victoria
Community Detox
7. **Susan Burgess, MD**
Family and Community Medicine Physician,
Providence Health Care / Vancouver Coastal Health
Clinical Associate Professor, Faculty of Medicine,
UBC
8. **Mike Burns, MD, CCFP**
Family Physician, Providence Health Care
9. **Jane A. Buxton, MBBS, MHSc, FRCPC**
Professor and Director MPH Practicum, School of
Population and Public Health, UBC
10. **David W. Byres, MSN, BA, RN, CHE**
Executive Vice President, Clinical Integration and
Renewal
Providence Health Care
Adjunct Professor, School of Nursing, UBC
11. **Rashmi Chadha, MBChB, MScCH, CCFP,
ABAM**
Addiction Medicine Physician, Vancouver Coastal
Health
Medical Consultant, College of Physicians and
Surgeons of British Columbia
12. **Veronic Clair, MD, MSc, CCFP, FRCPC, PhD**
Addiction Medicine Physician, Vancouver Coastal
Health
Adjunct Professor, Faculty of Health Sciences, SFU
Clinical Faculty, Faculty of Medicine, UBC
13. **Trevor A. Corneil, MHSc, MD, FCFP, FRCPC**
Chief Medical Health Officer, Interior Health
Drug Overdose and Alert Partnership Committee
Member
Clinical Professor, School of Population and Public
Health, UBC
14. **Cassandra Djurfors, MD, CCFP**
Medical Coordinator, Raven Song Primary Care,
Vancouver Coastal Health
15. **Richard Dubras, MSc, MEd**
Executive Director, Richmond Addiction Services
Society
British Columbia Association of Clinical
Counsellors
16. **Nadia Fairbairn, MD, FRCPC**
Fellow, St. Paul's Hospital Goldcorp Addiction
Medicine Fellowship
17. **Caroline Ferris, MD, CCFP, FCFP**
Primary Care and Addiction Medicine Physician
Clinical Assistant Professor, Faculty of Medicine,
UBC
18. **Michelle Fortin**
Co-Chair, B.C. Alliance for Mental Health/Illness
and Problematic Substance Use
Executive Director, Watari Counselling & Support
Services
19. **Emilie Gladstone, MPH**
Pharmaceutical Policy Researcher, Centre for
Health Services and Policy Research, Faculty of
Medicine, UBC

20. Silvia Guillemi, MD
Assistant Director, J. Ruedy Immunodeficiency
Clinic (IDC), St Paul's Hospital
Director of Clinical Education, B.C. Centre for
Excellence in HIV/AIDS
Clinical Associate Professor, Faculty of Medicine,
UBC
21. David Hall, MD, CCFP
Medical Director for Primary Care, Vancouver
Coastal Health
Medical Lead, Regional HIV Program, Vancouver
Coastal Health
22. Scott Harrison, RN, BScN, MA, CCHNC
Director Urban Health & HIV/AIDS, Providence
Health Care
Adjunct Professor, School of Nursing, UBC
23. Kanna Hayashi, PhD
Research Scientist, Urban Health Research
Initiative, B.C. Centre for Excellence in HIV/AIDS
Assistant Professor, Faculty of Medicine, UBC
24. Ramm Hering, MSc, MD, CCFP, Dip PH
Family and Addiction Medicine Physician,
Pandora Clinic
25. Lorne Hildebrand
Executive Director, EDGEWOOD
26. Ronald Joe, MD
Associate Medical Director, Addiction Services,
Vancouver Coastal Health
27. P.R.W. Kendall, B.C. Provincial Health Officer
28. Thomas Kerr, PhD
Director, Urban Health Research Initiative
B.C. Centre for Excellence in HIV/AIDS
Professor, Faculty of Medicine, UBC
29. Piotr Klakowicz, MD, MPH, CCFP
Family and Addiction Medicine Physician,
Providence Health Care
Vancouver Native Health Society Medical Clinic
30. Erin Knight, MD, CFPC
Fellow, St. Paul's Hospital Goldcorp Addiction
Medicine Fellowship
31. Mel Krajden, MD, FRCPC
Medical Head, Hepatitis, B.C. Centre for Disease
Control
Acting Medical Director, Public Health Laboratory,
B.C. Centre for Disease Control
32. Andrea Krüsi, PhD
Research Scientist, Gender and Sexual Health
Initiative, B.C. Centre for Excellence in HIV/AIDS
33. Leslie Lappalainen, MD, CCFP
Family and Addiction Medicine Physician,
Providence Health Care
Clinical Instructor, Faculty of Medicine, UBC
34. Julia MacIsaac, MD, MPH, FRCPC
Family and Addiction Medicine Physician,
Providence Health Care
Alliance Clinic, Surrey, B.C.
LAIR Centre, Vancouver
35. Brandon Marshall, PhD
Assistant Professor, Department of Epidemiology,
Brown University School of Public Health
36. Leslie McBain, Community Advocate
Moms United and Mandated to Saving the lives of
Drug Users (MumsDU)
37. Rita McCracken, MD, CCFP
Associate Head, Providence Health Care
Clinical Assistant Professor Faculty of Medicine,
UBC
38. Garth McIver, MD
Medical Consultant, B.C. Methadone Program
(CPSBC)
39. Mark McLean, MD, FRCPC
Addiction Medicine Physician, Providence Health
Care / Vancouver Coastal Health
40. Ailve McNestry, MB, CCFP, CCBOM
Deputy Registrar, Drug Programs
College of Physicians & Surgeons of B.C.
41. M-J Milloy, PhD
Research Scientist, Urban Health Research
Initiative, B.C. Centre for Excellence in HIV/AIDS
Assistant Professor, Faculty of Medicine, UBC
42. Julio S.G. Montaner, OC, OBC, MD, DSc
(hon), FRCPC, FCCP, FACP, FRSC
Professor and Head, UBC-Division of AIDS
UBC and St. Paul's Hospital Foundation Chair in
AIDS Research
Director, B.C. Centre for Excellence in HIV/AIDS,
St. Paul's Hospital, Providence Health Care
43. Steve Morgan, PhD
Professor, School of Population and Public Health,
UBC

44. Lisa Muhler, PhD in Addictions Counselling
Registered Psychologist
Clinical Director, Top of the World Ranch
Treatment Centre
45. Seonaid Nolan, MD, FRCPC, Dip ABAM
Internal Medicine and Addiction Medicine
Physician, Providence Health Care
Research Scientist, Urban Health Research
Initiative, B.C. Centre for Excellence in HIV/AIDS
Clinical Assistant Professor, Faculty of Medicine,
UBC
46. Michael Norbury, MBChB, MSc, BSc (Hons),
CCFP
Family and Addiction Medicine Physician,
Vancouver Coastal Health
47. Daniel Paré, MD, CCFP
Inner City Primary Care & Assertive Community
Treatment Team, Vancouver Coastal Health
Medical Coordinator, Downtown Community
Health Centre
Clinical Instructor, Faculty of Medicine, UBC
48. Gerrard Prigmore, MB, BCh, MRCP, DFRH,
CCFP, Dip ABAM
Family and Addiction Medicine Physician, Prince
George
49. Nitasha Puri, MD, CCFP, Dip ABAM
Family and Addiction Medicine Physician,
Vancouver Coastal Health / Portland Hotel Medical
Clinic / Fraser Health Authority
Clinical Instructor, Faculty of Medicine, UBC
50. Dan Reist, MTh
Knowledge Exchange Assistant Director
Centre for Addictions Research of B.C., University
of Victoria
51. Lindsey Richardson, DPhil
Research Scientist, Urban Health Research
Initiative, B.C. Centre for Excellence in HIV/AIDS
Assistant Professor, Department of Sociology, UBC
52. Launette Rieb, MSc, MD
Family and Addiction Medicine Physician
Clinical Associate Professor, Faculty of Medicine,
UBC
53. Kimberly Rutherford, MD, MSc, CCFP
Medical Coordinator, Primary Outreach Services,
Vancouver Coastal Health
Medical Staff, St. Paul's Hospital, Providence
Health Care
Clinical Instructor, Faculty of Medicine, UBC
54. Andrea Ryan, BSc, MD, CCFP
Family and Addiction Medicine Physician,
Providence Health Care
Vancouver Detox Physician, Vancouver Coastal
Health
55. Mark Sadler, MC
Addiction Counsellor
Executive Director, Top of the World Ranch
Treatment Centre
56. Todd Sakakibara, MD, CCFP, FCFP, Dip
ABAM
Family and Addiction Medicine Physician,
Vancouver Coastal Health
Clinical Associate Professor, Faculty of Medicine,
UBC
57. Kate Shannon, MPH, PhD
Director, Gender and Sexual Health Initiative
B.C. Centre for Excellence in HIV/AIDS
Associate Professor of Medicine, Faculty of
Medicine, UBC
Associate Faculty, School of Population and Public
Health, UBC
58. David H. Smith, MD, Dip ABAM
Okanagan Psychiatric Services, Interior Health
Clinical Instructor, Faculty of Psychiatry, UBC
59. Marshall K. Smith
Director of Corporate Development and
Community Relations
Cedars at Cobble Hill Addiction Treatment Centre
60. Kate Smolina, PhD
Banting Postdoctoral Fellow, Centre for Health
Services and Policy Research
School of Population and Public Health, UBC
61. M. Eugenia Socias, MD
Researcher, B.C. Centre for Excellence in HIV/
AIDS
Postdoctoral Fellow, Department of Medicine, UBC
62. Tim Stockwell, PhD
Director, Centre for Addictions Research of B.C.
Professor, Department of Psychology, University of
Victoria
63. Lorinda Strang
Executive Director, Orchard Recovery Center

64. Christy Sutherland, MD, CCFP, Dip ABAM
Medical Director, Portland Hotel Society
Community Services Society
Family and Addiction Medicine Physician,
Providence Health Care
Clinical Assistant Professor, Faculty of Medicine,
UBC
65. Lianping Ti, PhD
Researcher, B.C. Centre for Excellence in HIV/
AIDS
Postdoctoral Fellow, Faculty of Medicine, UBC
66. David Tu, MD, CCFP
Family and Addiction Medicine Physician,
Vancouver Native Health Society
Clinical Associate Professor, Faculty of Medicine,
UBC
67. Devin Tucker, MD
Addiction and Family Medicine Physician,
Vancouver Coastal Health
68. Mark Tyndall, MD, ScD, FRCPC
Executive Medical Director, B.C. Centre for
Disease Control
Deputy Provincial Health Officer, Province of
British Columbia
Director, UBC-BCCDC Research Institute
Professor, School of Population and Public Health,
UBC
69. Karen Urbanoski, PhD
Canada Research Chair in Substance Use,
Addictions and Health Services
Scientist, Centre for Addictions Research of B.C.
Assistant Professor, University of Victoria
70. Sharon Vipler, MD
Family and Addiction Medicine Physician,
Providence Health Care
71. Dan Werb, PhD
Director, International Centre for Science
in Drug Policy
72. Evan Wood, MD, PhD, ABIM, FRCPC
Professor of Medicine, Canada Research Chair in
Inner City Medicine, UBC
Medical Director, Community Addiction Services,
Vancouver Coastal Health / Providence Health Care
73. Steven Yau, MD, CCFP
Primary Care Physician, Downtown Community
Health Centre, Strathcona Mental Health Team and
Assertive Community Treatment Team, Vancouver
Coastal Health
Clinical Assistant Professor, Faculty of Medicine,
UBC
Medical Director, IMG Programming, Division of
Continuing Professional Development, Faculty of
Medicine, UBC

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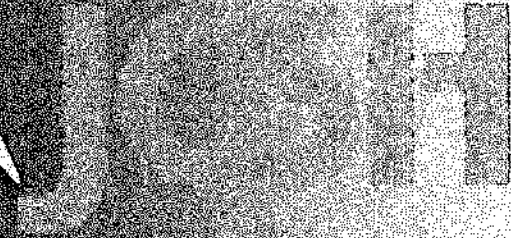
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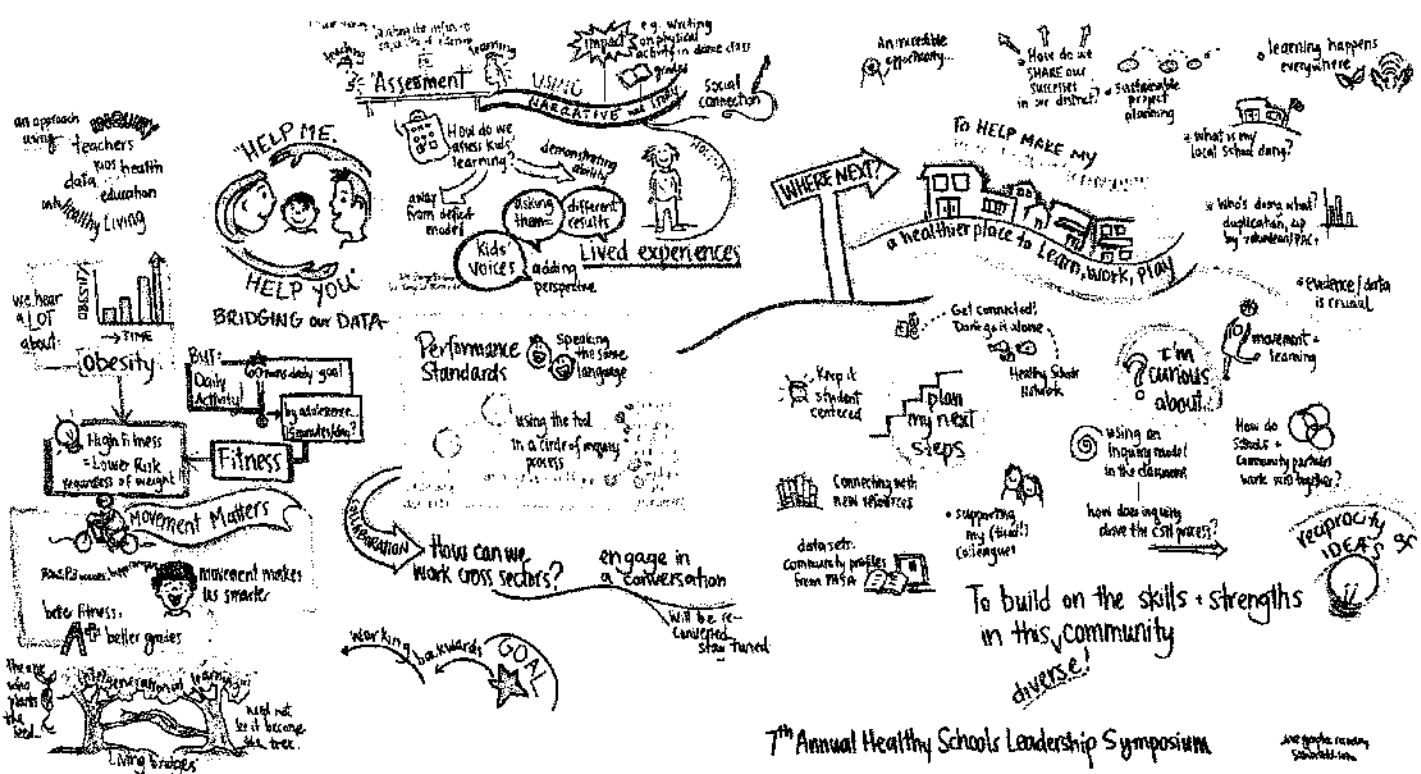
Inter-Canadian Partnership for School Health

Governments Working Across the Health and Education Sectors

Annual Report

September 30, 2015





This live graphic illustration represents the ideas and participation of attendees at the 7th Annual BC Healthy Schools Leadership Symposium held in Vancouver, BC on May 6, 2013. Artist – Sam Bradd.

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Message from the Executive Director



Any organization, in order to survive and achieve success, must have a sound set of beliefs on which it premises all its policies and actions."

-- Thomas Watson Jr.

I am pleased to present the 2015 Annual Report of the Pan-Canadian Joint Consortium for School Health (JCSH), summarizing the latest achievements of our member and participating jurisdictions as well as our collective progress.

We are excited to have received a third five-year mandate from the FPT Ministers of Health/Healthy Living and PT Ministers of Education to facilitate a comprehensive approach to health promotion in the school setting. In this new mandate, Prince Edward Island continues the role of lead jurisdiction and host of the Secretariat.

Since its inception in 2005, the JCSH has made remarkable progress and begins this 2015-2020 mandate with strong strategic priorities such as: Advancing the principles of comprehensive school health through policy, practice, and research; Developing a comprehensive research and knowledge exchange strategy; and Promoting provincial and territorial efficiencies and effectiveness by developing and adapting tools and resources that support use of a comprehensive school health approach.

In the year ahead, as we build on our progress, we will also ensure that our key directions are maintained: Leadership, Knowledge Development and Exchange, Capacity Building, and Evaluation. These four areas directly support our three long-term outcomes: Increased Inter-Sectoral Action between Education and Health; Increased System Capacity, Collaboration, and Efficiency; and Increased Research Coordination. To these outcomes are directed our work in the areas of positive mental health, youth engagement, and the links between comprehensive school health and student achievement.

The collaboration and collective initiatives of the JCSH are founded on evidence-based practice, collaboration, diversity and inclusion, equity, and innovation. As has been the case for the past 10 years, the JCSH member provinces and territories remain committed to these values and to the learning, health, and well-being outcomes of all children and youth in Canada.

A handwritten signature in dark ink, appearing to read 'Katherine Eberl Kelly'.

Katherine Eberl Kelly
Executive Director
Pan-Canadian Joint Consortium for School Health

Introduction

The Case for Cross-Sector Collaboration

Fostering collaboration across the sectors of health and education to support healthy school communities has been the over-arching aim of the Pan-Canadian Joint Consortium for School Health (JCSH) since its inception in 2005. The JCSH brings together education and health ministry officials from nine provinces and three territories with support from the federal government to work horizontally and collaboratively in order to advance and disseminate research, practice, and policy developed in Canada and around the world to improve learning and health outcomes in children and youth.

This collaboration enables the Consortium to provide tools, resources, and a national forum for sharing knowledge, coordinating priorities, and aligning the work of health and education professionals throughout the country. Their membership in the Consortium enables the jurisdictions to leverage products and knowledge to enhance capacity within their broad school health communities.

Working together across sectors and jurisdictions has resulted in cost savings and efficiencies for the member provinces and territories. By sharing initiative successes, working with practice and research experts, exchanging knowledge, and coordinating strategies, member and supporting jurisdictions can reduce the human and financial costs of the silo effects of overlap and duplication. By creating resources that have been developed with the collective skill of research teams throughout the country, JCSH supports provinces and territories with access to products they could not generate individually. While each jurisdiction's needs and strengths are unique, combining forces allows each to progress towards shared goals.

There are also significant long-term rewards for governments working across the health and education sectors. Research shows, and teachers and health professionals know, that healthy learning environments support both student wellness / well-being and student achievement¹. Educators, nurses, nutritionists, and other school experts in JCSH member and supporting jurisdictions are able to share evidence and best practices from Canada and around the world. The Consortium engages with national and international leaders in policy, practice, and research to work toward shared outcomes so that all students are able to reap the benefits of new educational and wellness directions. For example, our focus on comprehensive school health aligns directly with the national and international attention being paid to personalized learning and education transformation: Team learning, problem solving, technological awareness, global appreciation, and critical thinking are enhanced within a whole school community approach to student achievement.

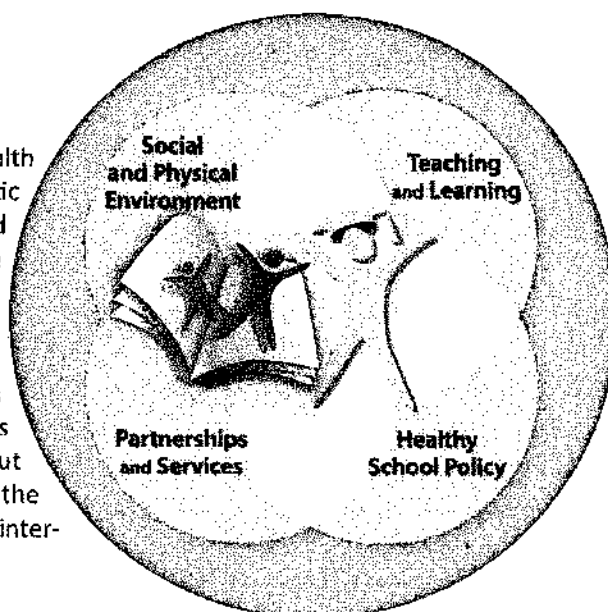
Collaboration for student health is critical, not just for children and youth, but for Canadian society as a whole. Chronic illnesses such as heart disease and type 2 diabetes afflict families, communities, and the health care system. The spirit of cooperation espoused by the Joint Consortium for School Health supports the growth of healthy environments and positive lifestyles to combat the escalating prevalence of these and other preventable diseases.

Collaboration for student achievement is equally important. The JCSH is founded on the belief that healthy students are better learners and higher education results in healthier individuals. Thus, education and health bring equal roles to the Consortium: Where student wellness is shown through physical activity, healthy eating, and positive mental health, student achievement is shown through learning competencies, autonomy, and connections with school, students, and staff, in addition to standardized test results.

¹Basch CE. (2011). Healthier students are better learners: high-quality, strategically planned, and effectively coordinated school health programs must be a fundamental mission of schools to help close the achievement gap. *Journal of Sch Health*. 81: 650-662.

About Comprehensive School Health

An internationally recognized framework, comprehensive school health (CSH) addresses school health in a planned, integrated, and holistic way in order to support improvements in student achievement and well-being. In provinces and territories throughout Canada, the links of healthy students with learning outcomes are made and built upon through a comprehensive school health perspective. The outcome from this integrated approach may be known as Healthy Schools, Health Promoting Schools, or Healthy School Communities in individual jurisdictions. The concept in all of Canada's provinces and territories is reflected in school curriculum and class projects but it is broader than what happens in the classroom. Rather, it involves the whole school community with actions addressing four distinct but inter-related components:



• Social and physical environment -

The social environment is:

- The quality of the relationships among and between staff and students in the school
- The emotional well-being of students
- Influenced by relationships with families and the wider community
- Supportive school community in making healthy choices by building competence, autonomy, and connectedness.

The physical environment is:

- The buildings, grounds, play space, and equipment in and surrounding the school
- Basic amenities such as sanitation, air cleanliness, and healthy foods
- Spaces designed to promote student safety and connectedness and minimize injury
- Safe, accessible, and supportive of healthy choices for all members of the school community.

• Teaching and learning -

- Formal and informal provincial / territorial curriculum, resources, and associated activities
- Knowledge, understanding, and skills for students to improve their health and well-being and enhance their learning outcomes
- Professional development opportunities for staff related to health and well-being.

• Healthy school policy -

- Policies, guidelines, and practices that promote and support student well-being and achievement and shape a respectful, welcoming, and caring school environment for all members of the school community.

• Partnerships and services -

Partnerships are

- The connections between the school and students' families
- Supportive working relationships among schools, and among schools and other community organizations and representative groups
- Health, education, and other sectors working together to advance school health.

Services are

- Community and school-based services that support and promote student and staff health and well-being.

Comprehensive school health (CSH) is an approach rather than a program or an initiative. As such, CSH is the mechanism through which issues such as physical activity, positive mental health, or injury prevention are addressed in school. For instance, in using a CSH lens an issue such as healthy weights is not addressed through any one program alone, or a school assignment, or a nutrition class. Rather, work to address healthy weights is reflected in many facets: through a social club in the school, and in the bicycle racks outside the school; as part of the teaching curriculum, as well as through professional development days for teachers and other school staff; through policy on the kinds of foods sold in schools, as well as the school's linkages with parents, community facilities, and groups.

When actions in all four components are harmonized, students are supported to realize their full potential as learners – and as healthy, productive members of society.

A Comprehensive School Health Approach to Health Promoting Schools

Health and education are interdependent: healthy students are better learners, and better-educated individuals are healthier. Research has shown that comprehensive school health is an effective approach to tap into that linkage, improving both health and educational outcomes and encouraging competencies, autonomy, and connectedness that last a lifetime².

In the school, comprehensive school health initiatives improve student achievement and can lead to fewer behavioural problems³. In the broader school environment, this approach requires more research to support student achievement in terms of self-efficacy, self-regulation, and coping strategies in addition to academic outcomes⁴.

Comprehensive School Health in Canada: Student Well-being and Student Achievement

Effective, sustainable progress in comprehensive school health depends on a common vision, shared responsibilities, and harmonized actions among health, education, and other sectors. The challenge is to coordinate these efforts so that partners pool resources and develop action plans together with, and in support of, schools. In Canada, the Joint Consortium for School Health, as the partnership of government ministries of education and health, models, supports, and encourages the collaborations between health and education that are essential to comprehensive school health.

Student-centred learning is a widely accepted approach to fostering a generation of young people who are healthy, happy, educated, and productive members of society. This approach applies the education of students to real-world issues. It celebrates technology, and global and cultural awareness as well as student mental fitness and student learning communities. The curriculum will be interdisciplinary, project-based, and research-driven. In this model, families and neighbourhood partners are essential members of the school community⁵.

²Murray, N.D., Low, B.J., Hollis, C., Cross, A., Davis, S. (2007). Coordinated school health programs and academic achievement: A systematic review of the literature. *Journal of School Health*, 77(9), 589-599.

³Stewart-Brown, S. (2006). What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach? Health Evidence Network Report. Copenhagen, DK: WHO Regional Office for Europe. <http://www.euro.who.int/document/c88185.pdf>.

⁴Hussain, A., Christou, G., Reid, M.A., & Freeman, J. (2013). Core Indicators and Measures (CIM) Framework for school health and student achievement in Canada. Summerside, PE: Pan-Canadian Joint Consortium for School Health (JCSH). <http://www.jcsh-cces.ca>.

⁵ASCD. *Making the Case for Educating the Whole Child*. [pdf 1.9M]. Alexandria, VA: ASCD; 2011.



About the Joint Consortium

Mandate

Established in 2005, the Pan-Canadian Joint Consortium for School Health is a partnership of federal, provincial, and territorial governments from across Canada, working together to promote the well-being and achievement of children and youth in the school setting. Recognizing that every province and territory has initiatives in place to foster healthy school environments, the Consortium brings together key representatives of government departments or ministries responsible for health and education to:

- strengthen cooperation among ministries, agencies, departments, and others in support of healthy schools
- build the capacity of the health and education sectors to work together more effectively and efficiently
- promote understanding of, and support for, the concept and benefits of comprehensive school health initiatives.

In 2015, the Provincial and Territorial Ministers of Education and Provincial and Territorial Ministers responsible for Health and/or Wellness agreed to continue the JCSH for the next five years. With a renewed mandate, the Consortium members have begun to consider and set the strategic priorities moving forward.

Vision

Children and youth in Canada thriving in school communities committed to optimal learning, health, and well-being.

Mission

To provide leadership and facilitate a comprehensive approach to school health by building the capacity of the education and health systems to work together.

Strategic Direction

The Consortium's long-term strategic direction continues to support the purpose of the JCSH: to be a catalyst to strengthen cooperation and capacity among the health and education ministries to better accomplish mutual goals and support shared mandates regarding the promotion of the health of children and youth in Canadian schools.

Goals

With the renewed mandate, the JCSH has adopted four goals to guide the strategic and operating plans.

1. Leadership

To advance the principles of comprehensive school health through policy, practice, and research.

2. Knowledge Development and Exchange

To build, share, and leverage knowledge to support the learning, health, and well-being of children and youth in Canada.

3. Capacity Building

To enable member jurisdictions to advance a comprehensive school health approach to support optimal learning, health, and well-being.

4. Monitoring, Evaluation, and Accountability

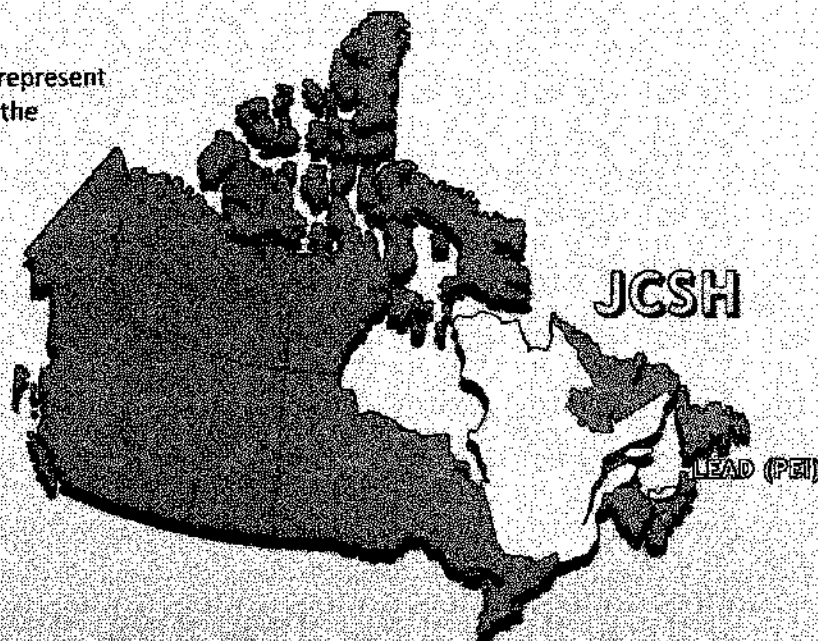
To develop and implement a comprehensive evaluation framework for the goals, strategies, and action plans of the JCSH 2015-2020 Strategic Plan.

JCSH Agreement 2015-2020.

JCSH Membership

Members of the Joint Consortium for School Health represent the health and education ministries/departments in the following jurisdictions:

- British Columbia
- Alberta
- Saskatchewan
- Manitoba
- Ontario
- New Brunswick
- Nova Scotia
- Prince Edward Island
- Newfoundland and Labrador
- Yukon
- Northwest Territories
- Nunavut



Under the 2010-2015 mandate, The Public Health Agency of Canada, representing the federal government at the JCSH table, is not a member of the Consortium but serves in a funding and advisory capacity.

Although Quebec shares the concerns and objectives of the JCSH and will continue to contribute by sharing information and leveraging best practices, Quebec intends to remain solely responsible for responding to school health needs within its territory.

Long Term Outcomes

The JCSH has committed to three overarching long-term outcomes. They are defined as follows:

1. Increased Intersectoral Action between Education and Health

The mandate of JCSH is to enhance collaboration between education and health ministries in the area of comprehensive school health, the JCSH four-component approach to addressing school health issues through social and physical environment, teaching and learning, partnerships and services, and healthy school policy.

2. Increased System Capacity, Collaboration, and Efficiency

JCSH supports the work of member jurisdictions and the federal government in using a comprehensive school health approach in the issues affecting student well-being and achievement. Relationships between education and health ministries and other key stakeholders -- including national and international organizations, non-government organizations, and research centres -- are focused on working together to address comprehensive school health issues and national priorities.

3. Increased Research Coordination

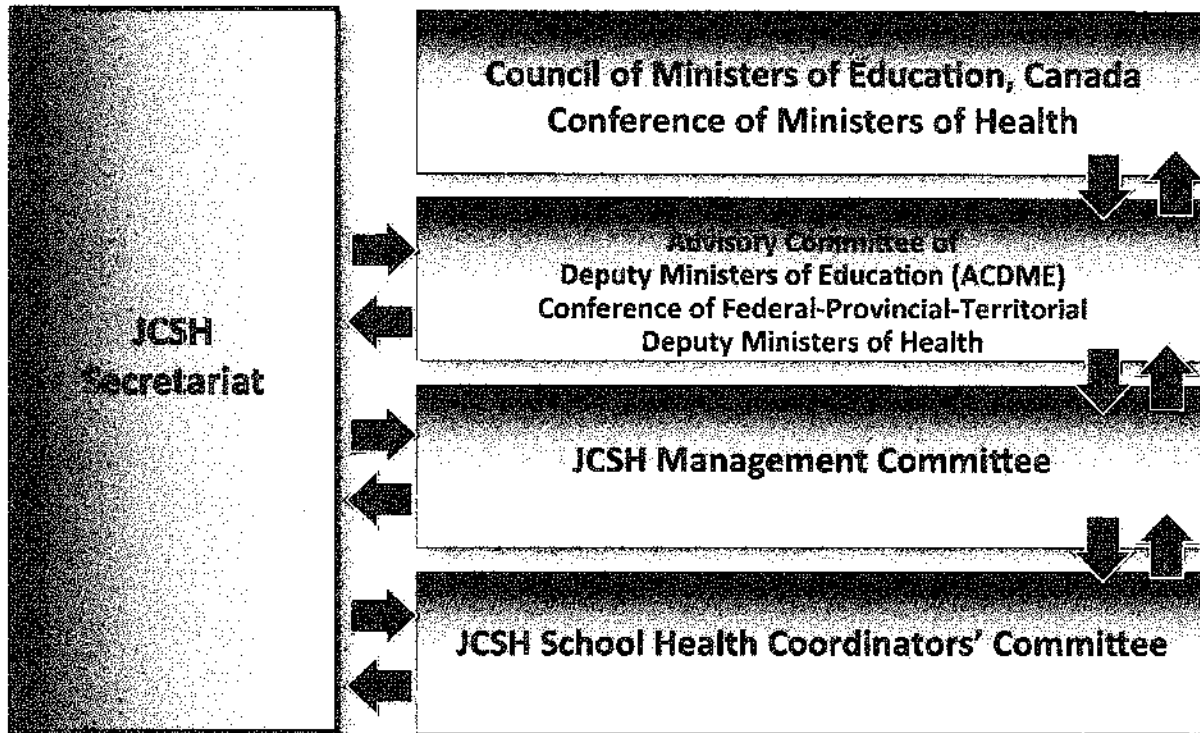
The JCSH establishes and maintains relationships with the research community and directs the priorities related to comprehensive school health to advance best evidence development and knowledge exchange.

Working Horizontally

Government services have traditionally used a "vertical" delivery structure in which each agency or organization has drawn a direct line from its leadership to the members of the public it serves. Today, governments are increasingly recognizing the value of "horizontal" initiatives -- structures in which partners from two or more organizations have established a formal funding agreement to work toward shared outcomes.

The Pan-Canadian Joint Consortium for School Health continues to break new ground in horizontal governance. Its mandate not only spans the health and education sectors, it also spans a dozen individual jurisdictions -- each with its own legislation, policies, history, culture, and bureaucracy.

Pan-Canadian Joint Consortium for School Health Organizational Structure



The JCSH is governed by two Deputy Ministers' committees – the Advisory Committee of Deputy Ministers of Education (ACDME) and the Conference of Deputy Ministers of Health.

The two committees of the JCSH responsible for the strategic direction and work agenda are

- the Management Committee
- the School Health Coordinators' Committee.

Management Committee

The Management Committee provides the main forum for executive level discussion and decisions affecting the work of the JCSH. The mandate of the Committee is to further the Consortium's strategic priorities, as communicated by the two Deputy Ministers' committees by:

- exchanging ideas, opportunities, and concerns related to existing and emerging issues;
- providing oversight and direction for major projects endorsed by the Consortium and undertaken by the Secretariat;
- providing guidance and supporting linkages between the Consortium objectives and jurisdiction-specific health and educational issues;
- participating in discussions and making decisions on strategic or operational matters, as required, to support the Secretariat in moving the Consortium's agenda forward; and
- offering a forum for discussion on other health and educational issues where appropriate.

School Health Coordinators' Committee

School Health Coordinators are drawn from senior policy analysts, consultants, managers, and specialists in the Ministries of Education and Health. The School Health Coordinators' Committee serves as a pan-Canadian forum to advance comprehensive school health initiatives across Canada, and to support collaboration and alignment between health and education sectors in the promotion of student success and wellness.

Through the early identification and analysis of issues, gaps, emerging trends and areas of interest to the JCSH and its member jurisdictions, the School Health Coordinators' Committee works collaboratively to move forward the work of the JCSH, provinces and territories.

JCSH Secretariat

The Secretariat is responsible for planning and coordinating activities of the Consortium. It monitors and facilitates progress on outcomes set by the Consortium mandate and organizes the meetings of the Management Committee and the School Health Coordinators' Committee. It is also the central point of contact for Consortium members and maintains an active communication with other related organizations. The Secretariat represents the collective voice and the collective impact of Consortium outcomes at meetings, conferences, and consultations across the country. It has a helpdesk function and maintains the website.

Consortium Accomplishments

The goal of student achievement and wellness is one adopted by governments throughout the world. Canada, through the work of the Pan-Canadian Joint Consortium for School Health (JCSH), advances this goal in health and education ministries and departments in provincial and territorial jurisdictions throughout the country. Because of this measure of cooperation, the JCSH is able to develop and maintain enduring partnerships, and is recognized as a leader in the area of comprehensive school health.

The JCSH provides its members with tools, resources, and a national forum through which to share knowledge, coordinate priorities, and strengthen alignment among Canada's health and education sectors. Its consistent and harmonized approach to horizontal collaboration is assisting this country in moving beyond traditional barriers to improve health and learning for children and youth in the school setting.

Highlights of progress in member and supporting jurisdictions are reported beginning on page 17.

Leadership

The fundamental leadership role of the JCSH is to facilitate the development and enhancement of the collective impact of education and health collaboration and of a comprehensive school health approach in every member province and territory. As the collective government voice of school health in Canada, the Consortium through its membership and Secretariat works to increase awareness across the sectors of the essential linkages between health and education in the lives and futures of all children and youth. The JCSH continuously monitors and reviews its work to ensure it is supporting integrated improvements in school-aged students' achievement and well-being.

On an ongoing basis, the work of the Consortium is undertaken and completed by its member representatives on the Management Committee, the School Health Coordinators' Committee, and the Secretariat. The JCSH is seen as a significant contributor to the school health field with an important role in making connections between organizations within and outside of government. As the only mechanism by which the government education and health sectors meet and work collaboratively at a pan-Canadian level, the JCSH is perceived as a cost-efficient means of developing resources, creating and sharing knowledge, and increasing the capacity for improving school health. The opportunity of knowledge exchange and collaborative activity provided by this mechanism is valued by members and partners.

The JCSH continues to follow the key recommendations and suggestions from the first-ever meeting of health and education ministries' senior officials held early in 2013:

- A comprehensive, whole student approach to student achievement and the contribution of comprehensive school health to the system of education
- The approaches to implementing authentic youth voice in a comprehensive school health approach
- The impact of JCSH on the core mandates of the ministries of health and education.

With its renewed mandate, the JCSH has adopted a goal of Leadership: To advance the principles of comprehensive school health through policy, practice, and research. Its work continues to support its long-term outcomes, in particular **Increased System Capacity, Collaboration, and Efficiency and Increased Research Coordination**.

JCSH advances and engages in the use, monitoring, and evaluation of three important resource areas:

The Healthy School Planner

Recognizing that schools are a key environment where students attain the knowledge and skills needed for lifelong health and well-being, the JCSH has revised and re-developed the Healthy School Planner (HSP) - an online tool to assist educators in assessing their school's health promoting environment and in making plans for improvements.



In the past year, an evaluation process was developed by the Propel Centre for Population Health Impact (Propel) at the University of Waterloo, with data collection to take place in autumn 2015 and results anticipated in early 2016.

- The Healthy School Planner was developed for the JCSH by the Propel Centre together with a JCSH Advisory Committee. The HSP is available in English and French for use by any school in the country, free of charge. A promotional video is also available in English and French.
- The Healthy School Planner was extensively piloted by teachers, researchers and experts in the field of comprehensive school health from across the country.
- In addition to the foundational module, the Healthy School Planner consists of four modules (healthy eating, physical activity, tobacco reduction and positive mental health).
- Using the HSP, school health is assessed by examining a school's overall wellness environment using the four components of comprehensive school health (CSH): social and physical environment, teaching and learning, healthy school policy, and partnerships and services.
- The Healthy School Planner recommends a school develop a team composed of educators and school administrators along with parents, students, public health experts, and community members to ensure a broad, informed assessment of the school and school community is conducted. This makes the assessment and planning more meaningful, more widely accepted, and much easier to implement.
- Upon completion of any one of the Healthy School Planner modules, schools receive results specific to their responses, tailored recommendations based on their results, and a list of action-oriented and jurisdiction-specific resources. Schools can share their results and achievements with staff, students, parents, and the broader community.
- School boards and districts can request an aggregate report of data generated by schools that use the Healthy School Planner. Approval must be sought from school superintendents or a designate. A data application form is available by following links to the "Frequently Asked Questions" or "Contact Us" pages on the Healthy School Planner website.

Youth Engagement Toolkit

Meaningful youth engagement is associated with young people's protection from risk, positive health outcomes, and student achievement. When young people are involved in decision-making, they feel connected to their school environment and community, they build relationships with their peers and adults, and they learn new skills. They are more likely to make healthy decisions, have healthy behaviours, and take fewer unhealthy risks. They are also more likely to do well in school and continue learning throughout their lifetime.

Recognizing that youth engagement is an integral aspect of comprehensive school health, the JCSH worked with Stoney McCart and her team at The Students Commission of Canada to develop the JCSH Youth Engagement Toolkit

The Toolkit provides the research and rationale behind youth engagement, and may be of assistance when communicating with stakeholders in healthy school communities, including schools and school boards/districts/divisions, government ministries, health regions, and community organizations.



The Toolkit also provides evidence-informed best practices and qualities of youth engagement, as well as tips on how youth engagement can be initiated and sustained.

Produced in an interactive “e-book” format in English and French, the Toolkit includes a number of videos, tools, and links to additional resources that can be used in planning for and evaluating youth engagement.

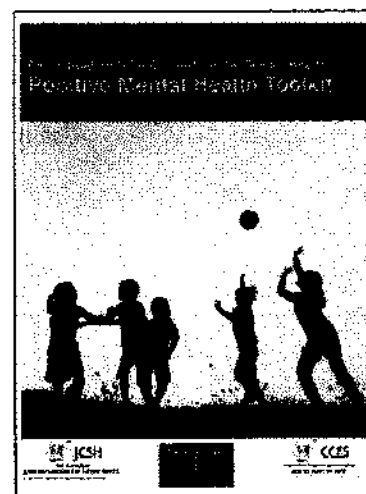
Positive Mental Health

A number of initiatives were undertaken under the umbrella of JCSH work in positive mental health in the past year.

The Positive Mental Health Toolkit remains a significant resource for the work in school communities throughout Canada. It is available in English and French in an interactive “e-book” format, and includes a number of videos, links, and resources used by schools to self-assess and plan for positive mental health practices in the school setting through a comprehensive school health approach.

In less than two years following adaptation of the Positive Mental Health Toolkit into a module of the Healthy School Planner, schools are showing increasing interest in this perspective in their healthy school assessment and planning for improvement. The valuable information provided in the JCSH toolkit was converted in 2013 to the format of the Healthy School Planner, providing the fourth of four topics covered by the school health self-assessment tool.

The 2nd Edition of the literature review and better practices statements on Positive Mental Health was written and published in 2013. This edition of Schools as a Setting for Positive Mental Health: Better Practices and Perspectives presents an updated and elaborated review of relevant research on positive mental health perspectives and practices within a school health context. In addition, educational and school health leaders and service providers present views on positive mental health approaches with, at the end of the book, convergent better practices emerging from the literature review and the key informant interview findings.



Knowledge Development and Exchange

The JCSH works as a bridge for policy, practice, and research. At a national level, the member representatives provide input on dialogues on student achievement and well-being outcomes and how these can be improved. At a school and school district level, tools and resources help shape the team gathered to assess the health of the school community, the engagement of students, the positive mental health of all. The resources that have been developed and / or championed by the Consortium all have, as their foundation, a holistic and integrated approach to changing health and achievement outcomes: having a team within the school community to assess the current situation and make a plan for sustained change through a comprehensive school health approach. These areas support the long-term goals of **Increased Inter-Sectoral Action Between Health and Education** and **Increased Research Capacity**.

With the renewed mandate, the JCSH has adopted a goal of Knowledge Development and Exchange: To build, share, and leverage knowledge to support the learning, health, and well-being of children and youth in Canada. This goal will assist the Consortium in maintaining focus on this area.

Research Coordination Initiatives

JCSH contributes to numerous research development and dissemination initiatives as part of its commitment to Increased Research Coordination. In 2014-2015, work continued in a key area:

Core Indicators and Measures of School Health and Student Achievement.

Table 1: Freeman-Hussain-JCSH Healthy Schools Framework

	COGNITIVE	BEHAVIOURAL	AFFECTIVE
ACADEMIC INDICATORS	<i>Achievement test scores: standardized tests, GPA, report cards</i>	<i>Attendance: absences, lates, suspensions / expulsions</i>	<i>Academic motivation: academic self-concept / self-efficacy, self-regulation, self-confidence, intrinsic/extrinsic motivation, coping strategies</i>
SUCCESS INDICATORS	<i>High school progression: graduation rates, graduating with Honours, credit attainment, drop-out rates, post-secondary plans</i>	<i>Student participation: number of activities in which students participate, type of participation (e.g., leadership; on-task/off-task), variety of participation (in-class, extra-curricular, community), quality of participation (student engagement, peer relationships)</i>	<i>Mental health: well-being, ill-being, suicidal tendencies, depression, school connectedness</i>
HEALTH INDICATORS	<i>Understanding of health: physical activity guidelines, screen time limits, nutritious eating, dangers of substance use</i>	<i>Health and health behaviours: physical activity, screen time, eating patterns, body composition, substance use, sexual behaviour</i>	<i>Motivations toward optimal health: attitudes, perceived behavioural control, subjective norms</i>
ENVIRONMENTAL INDICATORS	<i>Understanding of Comprehensive School Health: student, teacher, school administrator, parent, community</i>	<i>Adult engagement: parent and family member authentic engagement in school, teacher and administrator professional development, community partnerships</i>	<i>Inclusive school environment: safety, accepting environment, positive school culture, healthy school "buy-in"</i>

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The JCSH collaborates with Dr. John Freeman and his research team at Social Program Evaluation Group, Queen's University, to disseminate and develop next steps for the major research work begun in 2013 on links between comprehensive school health and student achievement. Ministries of education and health in this country and internationally are interested in determining whether comprehensive school health initiatives really do result in improved student achievement. The JCSH commissioned Dr. Freeman and his team to conduct research in this area. In this work, entitled Development of the Core Indicators and Measurements Framework for School Health and Student Achievement in Canada, a framework was developed of academic, success, health, and environmental indicators. Among the findings of the research:

- Lack of literature on comprehensive, integrated, and holistic approaches to school health (most research studies focused on a single aspect of school health, commonly, healthy eating and physical activity);
- Lack of research in the unique Canadian context (much research was conducted in the United States);
- Lack of a broad-based understanding in the research on student achievement (researchers tended to see student achievement as individual academic achievement).

In the past year, the original framework was revised to incorporate health indicators with the initial academic,

success, and environmental indicators. This revision begins the next steps of knowledge exchange and consultation on this work. Future work plans include expanding the research on comprehensive school health within the Canadian context.

Presentations and Partnerships

Further to its work in the goals of Leadership and of Knowledge Development and Exchange, the JCSH is invited regularly to participate in national and international forums, workshops, and dialogues on matters related to school health and, more broadly, on strategies to develop and sustain cross-sector collaboration.

Over the past year, the JCSH has worked in an advisory and consulting capacity with a number of partners:

The Mental Health Commission of Canada's National Strategy: Development of Progress Indicators. Among the data sources are responses from the Healthy School Planner Foundational Module.

Canadian Centre on Substance Abuse: a one-day, pan-Canadian meeting in Ottawa to address illicit and recreational substance use among youth who participate in sport.

Planning committee for 2015 National Healthy School Communities Forum, hosted by Physical and Health Education (PHE) Canada.

JCSH staff and members made presentations to a wide variety of workshops and conferences over the past year, and represented the collective voice of education and health ministries on school health in meetings of national organizations, research groups, and agencies. The presentations address JCSH's long-term goal of **Increased Intersectoral Action Between Health and Education**.

Comprehensive school health, positive mental health, the links of comprehensive school health and student achievement, and the success of policy / practice / research collaborations were profiled during the following national conferences and workshops (through presentations, display booths, knowledge pieces in delegate packages). JCSH Secretariat and members participated in these events with the purpose of engaging in knowledge transfer and exchange with key stakeholders in Canada and internationally working in the inter-connected fields of youth and child health and education / school health:

- During the 2014 meeting of the Advisory Committee of Deputy Ministers of Education (ACDME), the Executive Director made a presentation on the work of JCSH and the proposal for mandate renewal.
- New Brunswick's 2014 Provincial Wellness Conference – Moncton NB: May 14-15 2014.
- 9th Conference on Recent Advances in the Prevention and Management of Childhood and Adolescent Obesity – Time to Focus on Strengths: Addressing Obesity in Indigenous Youth – Winnipeg MB: September 24-26 2014.
- Ever Active Schools' 6th annual Shaping the Future Conference – Kananaskis AB: January 29-31 2015.
- Physical and Health Education (PHE) Canada Health Promoting Schools Project – series of workshops across Canada: Spring 2015.
- Interdepartmental Working Group on Children's Rights (IWGCR) presentation – via teleconference: April 28 2015.
- Healthy Schools BC 9th Annual Symposium – Vancouver BC: May 4-5 2015.
- Canadian Public Health Association (CPHA) annual conference, Public Health 2015 – Vancouver BC: May 25-28 2015.
- Canadian Council on the Social Determinants of Health presentation – via teleconference: June 5 2015.
- Canadian School Boards Association (CSBA) Annual Congress / National Trustee Gathering on Aboriginal Education – Saskatoon SK: June 30 – July 5 2015.

The 2014 Annual Report was distributed to partners and stakeholders across the country in print format and online at the JCSH website: www.jcsh-cces.ca.

The JCSH website underwent a major renewal and redesign in 2014 and is now able to provide greater interactive capabilities and a platform for sharing resources of interest to a wide range of audiences: from teachers and health

professionals, to government officials and researchers, to families and school communities. The resources comprise those developed by JCSH as well as provincial / territorial, national, and international communications.

Capacity Building

A critical part of the Consortium's work is to build the capacity of the health and education sectors to collaborate more effectively. At the same time, it supports the work of member jurisdictions and the federal government to build their respective capacities to design and deliver comprehensive school health initiatives. In the past year, the JCSH has leveraged resources to identify and challenges to implementation of comprehensive school health as a pathway to student success through improved achievement and well-being. The identification of the challenges is a necessary precursor to developing supports so schools and school districts reach measurable and sustainable goals.

With the renewed mandate, the JCSH has adopted a goal of Capacity Building: To enable member jurisdictions to advance a comprehensive school health approach to support optimal learning, health, and well-being. This goal will support JCSH's work within and among the provinces and territories in Canada.

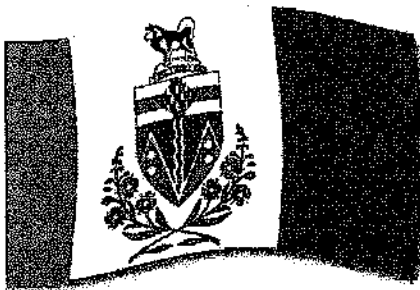
- JCSH continues to promote and share its tools and resources, such as the Youth Engagement Toolkit and the Positive Mental Health Toolkit, supporting coordinated and comprehensive improvements in student engagement, well-being, and achievement in schools. In the coming year, these resources will be monitored for use and adaptation to complementary formats, such as short description documents.
- A new evaluation of the Healthy School Planner will be carried out in the coming year to determine the extent of its use in Canadian schools and to document feedback on ways to improve its implementation in and benefits to schools.
- The JCSH continues to work with partner agencies and organizations to assist them in using comprehensive school health and the Healthy School Planner in developing professional development training programs and project funding envelopes.
- The JCSH commitment to education and health sector collaboration across the jurisdictions continues to be felt in the benefits expressed by members from the four pan-Canadian face-to-face meetings and 12 teleconferences of our member and supporting jurisdictions held over the past year. Evaluations showed that members agreed or strongly agreed that face-to-face meetings are a valuable use of their time and provided opportunity for cross-jurisdictional connections and resources sharing. This benefit is substantial and ongoing and measurable: the development of formal and informal relationships among the Management Committee members, the School Health Coordinators' Committee members, and the Secretariat staff over the life of the Consortium has impacted changes in school health in Canada.

Highlights of Progress in Member and Supporting Jurisdictions

The Pan-Canadian Joint Consortium for School Health serves as a catalyst, promoting cooperation and collaboration between and among member and supporting jurisdictions – and the health and education sectors – in support of comprehensive school health approaches.

Highlights of progress in member and supporting jurisdictions are included here to illustrate the range of activities underway across Canada during the year, and to demonstrate the work being done at all levels to advance comprehensive school health.

Please note: The accomplishments listed in this section reflect progress made during 2014-2015. For more information on any initiatives listed, visit the jurisdictions' respective school health websites. See Appendix D for member and supporting jurisdictions' contact information and web links.



Yukon

Since 2005, Yukon Education and the Department of Health & Social Services have provided support for the development of policy and practices in the areas of health and wellness in the schools.

The desire for Health and Education to work in partnership is reflected by the formation of the Healthy Living Steering Committee. This committee is made up of health and educational professionals, representing the Departments of Health, Education, and Community Services. The mandate of the steering committee is to coordinate Yukon responses to a number of Federal/Provincial/Territorial, Provincial/Territorial, and nongovernment health and wellness commitments. The Healthy Living Steering Committee facilitates information sharing, expertise, joint planning, and research on healthy living amongst Yukon Government departments towards joint comprehensive school health.

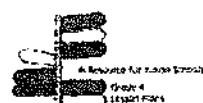
There is also a renewed emphasis and recognition of the positive impacts that the creation of health promoting environments has in school communities.

Leadership

- **Sexual Health and Relationship Education – SHARE** is a state of the art, comprehensive sexual health education program for Grades 4 – 7, designed by Yukon educators and the Health Promotion Unit. SHARE includes
 - Detailed step-by-step lesson plans that teachers can read word for word, depending on their experience in a particular topic, linked to the BC Prescribed Learning Outcomes
 - Student Activity pages for every lesson that can also be printed as a complete booklet
 - Assessment tools for teachers and students.

SHARE is designed as a roadmap, with a variety of routes provided to teachers to reach the same health outcomes for students. Grade 4 SHARE is complete and available for immediate use. Teacher lesson plans and student workbooks for Grade 5 – 7 are available by year end 2015. Although sexual health has always been taught in Yukon schools, SHARE provides a single, comprehensive resource for educators that is relevant in the modern digital age (significant focus on internet safety).

SHARE
Sexual Health and Relationship Education



- Yukon Education has a Yukon Self-Regulation Initiative to support children in building the capacity to ensure they have adequate energy, alertness, or calmness to deal with everyday life stress. A group of educational specialists provide advice on classroom adaptations to reduce environmental stressors, and introduce sensory and movement breaks, as well as down-regulatory and calming breaks. More intensive interdisciplinary supports are provided to individual students.
- Yukon Education is undertaking a preventative approach to supporting comprehensive

school health in students through a safe and caring schools policy. Support for the policy includes collaboration on response to bullying behaviours and social-emotional classroom based support.

- **Creation of Healthy Food Environments:**

- Vending machines in schools – Health Promotion has supported the introduction of a Healthy Foods vending machine at Vanier Secondary School as part of the creation of healthy food environments. The cafeteria contractor is mandated to fill the machine with fresh, healthy foods at low cost to students. This project will undergo an evaluation in spring 2015.
- Health Promotion continues to be an active participant in the Healthy Food and Beverage and Healthy Beginnings Committees to provide healthy food guidelines in early childhood education and recreation facilities.
- From the Ground Up Health Choice Fundraiser for schools underwent a significant expansion in 2014, to incorporate 2 Yukon farmers and a total of 49,510 lbs of fresh vegetables being sold to support school endeavors, many of which included self-regulation items such as bikes. This program will continue in 2015.
- The Health Promotion Unit continues to provide Teacher Education Bulletins on healthy eating topics such as using food as a reward, energy drinks, and healthy celebrations in classrooms.

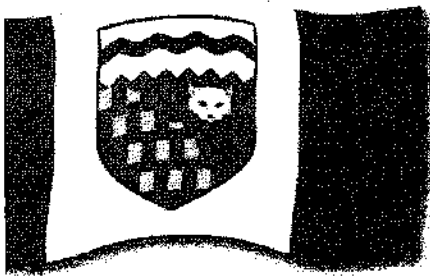
Knowledge Development and Exchange

- Yukon Education and the Health Promotion Unit have partnered on the 2014/2015 cycle of The Health Behaviour in School-aged Children survey in Yukon. This has become both a financial and philosophical partnership to guide programming and policy development for youth across Yukon. Health Promotion has contracted to gain access to the Yukon report in early spring 2015.
- Yukon Education publishes a monthly newsletter, *Wellness Perspectives*, for school staff. Topics highlighted include Comprehensive School Health, self-regulation, health and wellness, social-emotional learning and inclusive educational practices. Strategies and tips are provided to promote wellness and resiliency in students, educators, and parents.
- Yukon Education offers healthy living programming including experiential science and outdoor educational courses, sports programming, culture camps, culturally relevant programming options, individualized programming and transition support, and rural educational opportunities.

Capacity Building



- **KICKIN' ASH** is a new tobacco prevention resource available in the spring of 2015 for NGOs and community groups and, by September, schools. This is a community-based program intended to build the capacity of youth serving agencies to prevent/delay tobacco use amongst young people. This will be a “living” document where groups can amend and add to program ideas as well as create a dialogue of support.
- Training opportunities are being offered to Yukon educators to support students in safe and caring school communities to support mental health and wellness. Training includes restorative practices, Nonviolent Crisis Intervention, suicide prevention training and Violence Threat Risk Assessment training.



Northwest Territories

The Healthy Choices Framework (HCF) is a collaboration among the Government of the Northwest Territories (GNWT) departments of Health and Social Services, Education, Culture and Employment, Municipal and Community Affairs, Justice, and Transportation, with other GNWT departments and agencies contributing to activities. Through the HCF and its public identifier, the 'Choose' logo, partner departments coordinate their efforts on many new Northwest Territories (NWT) health promotion and student success initiatives.

Leadership

- NWT teachers' conference - The NWT Teachers' Association in partnership with the Department of Education, Culture and Employment hosted a three-day conference attended by all NWT educators. Sessions that focused on teacher and student wellness included topics such as Mental Health First Aid, gender diversity, self-regulation, and restoring balance in adult-child relationships.
- Healthy Food for Children and Youth – 2014-15 was the first year of new, sustained funding for three programs impacting the nutrition of children and youth. Funds will support the school-based *Healthy Food for Learning Program*, after school snacks within the *After School Physical Activity Program*, and *Healthy Food Kitchen/Collective Kitchen* supports for families.
- "Weaving Our Wisdom" – A three-day conference that included delegates from every NWT community and representatives of Aboriginal governments, non-governmental organizations, and health professionals focused on exploring ways to work together to improve the overall well-being of northern residents and close the health status gap between Aboriginal and non-Aboriginal people. Youth delegates participated in plenary sessions and held concurrent youth-focused sessions that culminated in a presentation of their wellness priorities.
- Regional Mental Health Anti-stigma Youth event – With support from the Mental Health Commission of Canada, a delegation of 10 youth attended a five-day national anti-stigma event and then worked with a coordinator to host a regional *Headstrong* event attended by student representatives from five high schools. Three speakers, including two northern youth, shared their hope-filled stories of journeying through mental health challenges.

Knowledge Development and Exchange

- Injury prevention – A seminar on March 7, 2015 brought together NWT educators, medical and recreation professionals, coaches, and parents to learn, discuss, and share information on concussion education tools and the policies/procedures required for students who are returning to learn and play after a concussion.
- Physical activity - A renewed partnership with the University of Alberta, the Department of Municipal and Community Affairs, and Deh Gah School in Fort Providence is engaged in a multi-year project aimed at increasing the overall physical activity levels of, and general health awareness in, the student population. A full-time physical literacy coordinator has been hired in the school to design and implement physical fitness activities intended to enhance healthy lifestyles and achieve sustainable results. Initial results will be available in 2016.
- Action Research – Departments of Health and Social Services and Education, Culture and Employment participated in a learning event to explore how action research/participatory research might be embedded within school-based programs of study. Action research kits to support classroom pilots were purchased in all education regions.

- Self-regulation strategies - A group of seven Aboriginal cultural/language “knowledge keepers” was assembled to share indigenous self-regulation strategies with Dr. Stuart Shanker, researcher, and education professionals. The session was recorded with audio equipment and by a graphic illustrator in order to develop resources that will enable sharing with NWT educators and community members.

Capacity Building

- Resilience grants – A new grant program provided funds to seven schools for resiliency projects. Each project is based on individual school/community contexts.
- Safe and Caring Schools supports –Resources and training for the *Fourth R* and *WITS* programs were provided to half of schools in NWT. A new grant program provided funds to 13 schools for School-Community based projects which focused on strengthening the foundation of healthy relationships amongst our schools and communities.
- Talking About Mental Illness (TAMI) – Using an evidence-informed approach to promote mental health and reduce stigma, TAMI uses contact-based education and school-based activities to educate, empower and engage youth in the exploration of mental health. The most powerful aspect of the 5 module program is when Northerners who are successfully living with or have recovered from a mental illness share their stories of recovery with the grade 8 students taking the program. Research has shown that it is the speaker module that has been the most critical for youth in reducing stigma. TAMI is currently offered in Yellowknife. A phased approach is being taken to expand to additional regions of the NWT.
- Self-Regulation (SR) – Support was provided to all schools in the form of grants, resource distribution, and access to online courses. Health and education staff at the headquarters and authority/board levels worked in partnership to host a territorial conference on whole-classroom and targeted SR support strategies.
- Residential schools - Teaching resources addressing the history and legacy of residential schools have been developed and are part of a course that is mandatory for graduation. The commitment to in-service all NWT teachers in the issues of residential schools was achieved. Two pieces of research related to the impact of this work have been completed showing significant impact on student and teacher understanding, empathy, and improved relationships between teachers and the communities in which they serve.

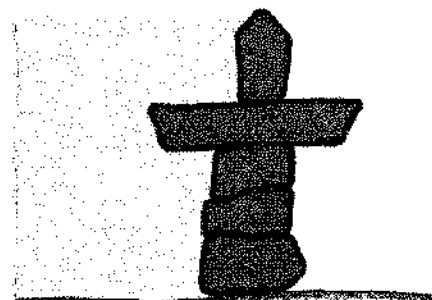


Nunavut

In *Sivumut Abluqta: Stepping Forward Together* (March 2014), the Government of Nunavut describes its 2014-2018 mandate and its vision of Nunavut in 20 years as

“...a place where physical and mental health has improved and where we are optimistic about our future. The rate of addiction and suicide has dropped dramatically...In the near term, community-based solutions must be supported to improve health, social well-being and local economies. In the long term, education and employment are key to addressing many of these issues. Education increases the options available to an individual.”

During the past year, the Departments of Education and Health continued to collaborate on their joint goals for the wellness of children and youth using a comprehensive school



health approach that is compatible with and promotes Aboriginal wellness (*Building on our Strengths: Aboriginal Youth Wellness in Canada's North*, Conference Board of Canada, January 2014).

Leadership

- Education completed a **review of inclusive education in Nunavut**. Guided by an advisory committee of educators, the objective of the review was to provide a guide for a practical model of inclusive education in Nunavut after identifying the gaps in services and the challenges of delivering appropriate programming. The review offered the Department of Education evidence-based recommendations that address the challenges of teaching and reaching all students in K-12.
- Education and Health moved forward on the **Healthy for Life Comprehensive School Health Strategy** by co-developing a **School-Based Positive Mental Health Framework** in consultation with health and education regional leads and Nunavut Tunngavik Incorporated. Phase 1 of this project aimed at providing universal and targeted socio-emotional teaching, intensive socio-emotional support, and crisis intervention is being completed.
- Education, Health, the Embrace Life Council and the Canadian Red Cross continued to provide leadership and training aimed at providing Nunavut's children and youth with personal safety skills. Through the **10 Steps Training Initiative**, three communities set up action teams to plan and address support for children and youth.
- As part of its renewed commitment to the **Nunavut Suicide Prevention Strategy**, the Government of Nunavut led an evaluation of the *2011-2014 Action Plan* and drafted the *2015-2018 Action Plan* with eight main commitments including strengthening the continuum of culturally-relevant mental health services; teaching children and youth the social-emotional and coping they need to respond to life's challenges; and fostering healthy development opportunities in early childhood.

Knowledge Development and Exchange

- In collaboration with the Nunavut Teachers' Association, Education finalized its comprehensive and practical **Crisis Response Guidelines for Nunavut Schools Staff Manual (2015)** detailing school protocols for emergency preparedness and responding to critical events, medical emergencies, cyber threats and bullying. The manual also provides a directory of networking and training opportunities related to comprehensive school health in the school, community and on the land.
- Education and Health produced a video documentary called *The Making of Choices* which explores the sexual health issues raised in the graphic novel *Choices* from the perspective of youth who were involved in its creation. Besides the documentary, the **sexual health education resource kit** available in English, Inuktitut, Inuinnaqtun, and French, contains the *Choices* graphic novel; a teacher's resource guide; an information letter for parents and guardians; evaluation surveys for teachers and students; and suggestions about how schools and health care providers may engage parents/ guardians and other community members in discussions about sexual health and sexual health education. Electronic versions of the graphic novel may be found on the Government of Nunavut's sexual health website: www.irespectmyself.ca.

Capacity Building

- Health and Education collaborated to create a **health promotion book series** for Grade 1 focusing on key health messages integrated with literacy programs. Topics in the book series include: physical activity, preventing the spread of germs, nutrition, and oral health. This story book series is to be launched in the 2015/16 school year.
- Further collaboration resulted in a **substance abuse prevention tool kit** containing lesson plans for teaching children aged 10-14 the risks of using marijuana, alcohol, inhalants, prescription drugs, and gambling. The lesson plans are accompanied by ready-to-use activities and resources that will be provided to Nunavut's educators in the 2015/16 school year.

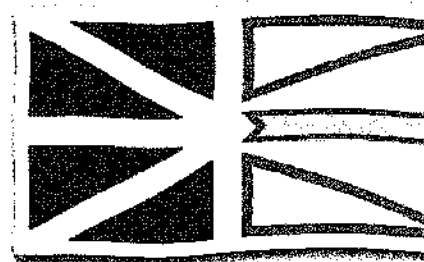
Newfoundland and Labrador

Healthy Students Healthy Schools (HSHS), a priority in the Provincial Wellness Plan, supports and promotes the creation and maintenance of healthy school learning environments and fosters healthy behaviours for life. Using a comprehensive school health approach, HSHS promotes healthy eating, physical activity, living smoke-free, injury prevention, mental health promotion, environmental health promotion, and positive social behaviours. Across the health regions and school districts, School Health Promotion Liaison Consultants (SHPLCs) strengthen partnerships, build capacity for school health, and facilitate health promotion initiatives in the school community. School health promotion is supported through the HSHS provincial website, regional/school district healthy living newsletters, health promotion workshops, and healthy living research, policies, and practices.

The Departments of Health and Community Services (HCS) and Education and Early Childhood Development (EECD) partnered on HSHS since 2004. The Department of Tourism, Culture and Recreation (TCR) became a partner in 2009 to support this interdepartmental school health promotion initiative. Based on a departmental reorganization in 2014, the responsibility for HSHS on the health side is now with the Department of Seniors, Wellness and Social Development (SWSD).

Leadership

- The EECD provided training for all guidance counsellors and educational psychologists on the Diagnostic and Statistical Manual of Mental Disorders and the Safe and Caring Schools Policy. The 134 Guidance Counsellors and 43 Educational Psychologists play a lead role in mental health promotion and prevention supporting students, parents, and educators.
- The EECD promoted the *Find Your Voice, Not Violence* Contest during Violence Awareness Week and collaborated with the Canadian Centre for Child Protection to provide students in Grade 7-10 with information on building healthy relationships and on the prevention of sexual exploitation, self/peer exploitation, cyberbullying and building healthy relationships.
- Information sessions were provided to community organizations on the Safe and Caring Schools Policy and Bullying Prevention and Intervention.
- EECD collaborated with Newfoundland and Labrador English School District (NLESD) to provide a professional learning session for Intermediate Home Economics teachers.
- Eat Great and Participate organized a Nutrition Month Youth Photo Contest in March 2015. Youth were encouraged to submit photos of themselves, friends, and



family completing weekly healthy eating and physical activity challenges. Several Community Youth Network afterschool programs participated and highlighted fun ways to incorporate healthy eating including a healthy Easter egg hunt!

- EECD, HCS, and the Canadian Mental Health Association, Newfoundland and Labrador division (CMHA NL) participated in the development of a pilot project as part of the Atlantic Canada Collaboration on Scaling up Social and Emotional Learning.
- Engaged in monitoring and evaluation efforts such as reviewing and updating health promotion materials, adjusting tracking mechanisms, and recognizing exemplary school food environments.
- Supported healthy sexuality through collaboration on the Sexual Health Clinic Project, development of LGBTQ classroom materials, and recognition of LGBTQ Stars.

Knowledge Development and Exchange

- The EECD released Guidelines for Diabetes Management in Schools in the fall 2014. This resource provides basic information for schools that have students with diabetes in their care. The guidelines clarify the roles and responsibilities of parents/guardians, educators, school administrators and other school-based personnel to ensure students with diabetes are provided a safe learning environment.
- In September 2014, schools and school communities in NL gained access to the new online program, Anaphylaxis in Schools: What Educators Need to Know. The program is designed to inform educators and others about the management of anaphylaxis, a severe allergic reaction on the rise in communities across Canada. The EECD contributed \$10,000 to partner with Anaphylaxis Canada to promote and use the program to help the school community learn more about how to protect young people at risk of suffering a major allergic reaction.
- The EECD released the Guidelines for Anaphylaxis Management in Schools in Winter 2015. This resource provides basic information for schools that have students at risk for anaphylaxis. The guidelines clarify the roles and responsibilities of the school community to ensure students at risk for anaphylaxis are provided a safe learning environment. Schools received an anaphylaxis resource kit in April 2015.
- The EECD is developing a best practice document focused on violence prevention and social-emotional learning for school personnel.
- EECD partnered with Sexual and Reproductive Health Consultants to develop professional learning video clips to support Grade 3 Health teachers.
- Enhanced communication with the school community using publications such as Living Healthy Newsletters, Healthy Relationships Banners, Rethink Your Drink Banners, and Healthy Holiday Recipe Celebration Collection.

Capacity Building

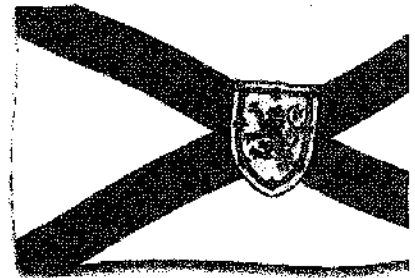
- Healthy living school projects were supported through Provincial Wellness, Regional Wellness Coalition, and Regional Health Authority Grants. Projects included school gardens, healthy living sessions (body image, bullying, physical activity, healthy eating), and the purchase of class snow shoes, yoga mats, and archery bows.
- Supported Participation Nation Unplugged with \$300,000 in addition to annual

funding of \$225,000 to provide school-aged children with recreational options that promote active lifestyles and overall wellness in the after-school time period. Participation Nation (PN) is a non-competitive recreational sport and physical activity program that encourages active and healthy living among all students and compliments the province's physical education and health curriculum.

- The EECD partnered with Egale Canada and the NLESD to provide train-the-trainer workshops to District personnel to prepare them to deliver LGBTQ Awareness workshops to all teachers in the province.
- The EECD provided \$5,000 funding to support mental health awareness for a student event at Holy Heart of Mary High School in St. John's.
- Agriculture in the Classroom NL expanded the number of classroom gardens in the Little Green Thumbs program to 70 classrooms, directly impacting 70 teachers, 25 mentors, and 1600 students.
- Funded and supported Living Healthy Commotions and associated online materials.
- Provided regional opportunities for students to be physically active through events such as outdoor physical activity days, Peter's River Raid Outdoor Adventure Race (Grades 4-12), Trek Terra Nova Adventure Race (Grades 6-12), Active After School Clubs and Community Champions, RBC Learn to Play, Running Coach seminars, and the Upper Lake Melville Jamboree.
- Implemented regional pilot projects and programs such as Wellness Café on Mental Health Promotion, SWAT (Student Wellness Action Teams) training sessions and programs, Life is Better Smoke Free Radio Ad Contest, Crunch and Sip Program, Queen of Peace School Seedling Program and Fresh Fruits Pilot Project.

Nova Scotia

Health Promoting Schools (HPS) was initiated in Nova Scotia in 2005 and is a partnership between the Nova Scotia Department of Education & Early Childhood Development, Nova Scotia Department of Health & Wellness, District Health Authorities, and School Boards. Funding is provided to eight public School Boards and the Mi'kmaw Kina'matnewey. The Boards work with their District Health Authorities and other partners to enhance student learning and health outcomes by strengthening school communities, as school communities provide an important setting for students to realize their potential. Partnership between the education and health systems is essential to ensure the areas for alignment between the two departments are identified and worked on collaboratively.



Leadership

- Each year funds are distributed to school boards to support HPS. The need to develop a funding formula was identified by the provincial HPS co-chair committee to ensure the funding supports HPS work in a way that is connected to current context and is based on evidence. A working group of HPS leaders across the province has developed the first HPS funding formula to come into effect for the 2015-16 school year. The formula is based on evidence, guiding principles, and the Nova Scotian context.
- A new interdepartmental committee was struck to support HPS and other initiatives where the education and health systems work together. The Department of Education and Early Childhood Development and Department of Health and Wellness Partnership Committee on Education and Health is composed of senior leaders in both departments. Its mandate includes

- providing leadership and coordination for joint initiatives related to student health and wellness
- providing recommendations to Deputy Ministers and Ministers on issues such as priority setting, stakeholder engagement, partnership development, and issues management.

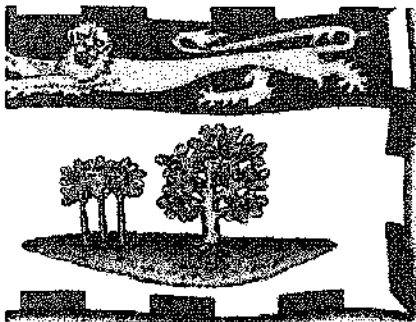
Among its objectives is to champion and build on successful collaboration models such as Health Promoting Schools.

Knowledge Development and Exchange

- Marketing to Children and Youth: A Public Health Primer was developed by the Department of Health and Wellness to:
 - increase understanding of the impacts of marketing on children and youth
 - identify common marketing strategies
 - support efforts to address marketing to children and youth in communities.

Capacity Building

- The departments of Education and Early Childhood Development and Health and Wellness introduced seven lesson plans on drug and alcohol prevention for Grades 7 to 9. The lesson plans are available as part of the current health education curriculum. Teachers, mental health clinicians, guidance counsellors, and school board administrators from across the province were invited to participate in training sessions to help them implement the lesson plans. So far, more than 300 teachers and counsellors have attended sessions. The province will provide ongoing support and coaching as needed. This resource for the Healthy Living curriculum is the first of its kind in Canada. It has been tested with youth in the province, is voluntary, and will help teachers meet mandatory learning outcomes for health education. Feedback on student engagement and response to the lessons from classrooms around the province has been positive.
- The Department of Education and Early Childhood Development released the Guidelines for Supporting Transgender and Gender-nonconforming Students to support schools and school boards in protecting and respecting students as they assert their gender identity and right to gender expression. The guidelines complement the amendments made to the Human Rights Act in December 2012 that protect transgender people from discrimination. They will help schools and school boards to create a culture that is safe, respectful, and supportive of transgender and gender-nonconforming students.
- The guidelines identify seven areas of support that include using the student's preferred name and pronoun, providing easy access to gender neutral washrooms and private change rooms, and providing all students with full access to physical education classes and extracurricular activities, including competitive sports, in a safe, inclusive, and respectful environment.



Prince Edward Island

Multi-sectoral partnerships have been critical in supporting the health, well-being, and achievement of students. Collaborative efforts have resulted in a variety of new and strengthened school health initiatives which have supported positive health behaviours and contributed to enhanced student success. Partners included the Department of Education Early Learning and Culture (DEELC), Department of Health and Wellness (DHW), Chief Public Health Office (CPHO), University of Prince Edward Island (UPEI)

researchers, provincial organizations, community groups, school boards, students, teachers, and parent volunteers.

Leadership

- The DEELC updated the Senior High School Graduation Requirements which will help ensure that physical education is recognized as a critical component of a student's academic program. The Minister's Directive outlined that PED401A (Grade 10 Wellness Curriculum) was added as a required credit for graduation. The new Wellness Curriculum helps develop confident and competent students who understand, appreciate, engage, and sustain a balanced, healthy, and active lifestyle.
- ParaSport and Recreation PEI and the DEELC hosted a **Physical Education Inclusion Summit**, the first of its kind in Canada. Grades K-12 physical education teachers, school board, and Department staff came together to discuss how to provide opportunities for all students to participate in physical education programs and to develop professional, inclusive, and accessible practices. As a follow up, a **ParaSport Festival** was held to educate people (including teachers, educational assistants, parents, and students) on the benefits of physical activity / sport and how to get involved.
- The DHW launched a new Wellness Strategy to support the physical and mental health of Islanders within a variety of settings. The five pillars of the Strategy include mental wellness, being physically active and reducing sedentary time, living tobacco-free, healthy eating, and responsible drinking behaviours. As a key setting to support the health and well-being of students through a comprehensive school health approach, the 'education system' is a key collaborative partner within the Strategy.

Knowledge Development and Exchange

- The DEELC, DHW, UPEI, the University of Waterloo, and Health Canada partnered to implement the 4th cycle of the School Health Action Planning and Evaluation System / Canadian Student Tobacco, Alcohol, and Drug Survey (SHAPES/CSTADS). The SHAPES/CSTADS system collected health behaviour data (healthy eating, physical activity, tobacco/alcohol/drug use, mental fitness) from over 10,000 students in Grades 5-12. This biennial survey provides schools, school boards, and the Province with student health profile reports which summarize key findings from the surveys. The 2014-15 data collection cycle included new funding partners such as go!PEI and the PEI Healthy Eating Alliance that utilize the SHAPES results to inform their work.
- Since 2008, the SHAPES-PEI system has supported knowledge exchange activities to encourage uptake and use of the survey results. The DEELC and UPEI hosted a Provincial Stakeholder Consultation to engage partners (volunteers, community organization, provincial alliances, and departments) that utilize the survey results to inform policy, practice, and programs. The consultation gathered suggestions of ways to improve the SHAPES-PEI system – both in the type of data collected and how the data is shared.
- Through an on-going partnership with the DEELC and UPEI, the **SHAPES-PEI Partner Engagement Strategy** continued to support the dissemination of survey results to help inform various policies and programs. Individualized presentations of the most recent findings were provided to multiple partners, for example
 - *Youth and Cyber-bullying: Creating a Collaborative Community Response* conference hosted by the Women's Network, PEI
 - Provincial Home and School Federation Semi-annual meeting
 - Intermediate Student Leadership Conference hosted by the PEI Physical Education Association.



Capacity Building

- The PEI Tobacco Reduction Alliance (PETRA), with collaborative support from the DEELC, DHW, and UPEI, developed two new curriculum and service resources:
 - Revealing the Truth – A Tobacco Media Awareness Resource for Teachers, a cross-curricular resource, aims to educate high school students about the harmful effects of tobacco products, the marketing tactics used by the tobacco industry, and education campaigns organized by public health organizations.
 - Supporting Island Students to Quit Smoking – A PEI High School Resource aims to inform high school staff of the variety of cessation services available for students.
- Through a new partnership of the Provincial Government, go!PEI, and the Canadian Tire Active at School initiative, the School Health Grant (SHG) provided 61 schools with \$2,000 of physical activity equipment in support of one hour of daily quality physical activity. The SHG has provided annual support for school-level health promotion programs and initiatives. School teams (students, teachers, parents) were asked to
 - examine their SHAPES-PEI student health profile reports
 - use the Healthy School Planner to assess their school health environment
 - identify school specific needs and priorities, and
 - develop action and evaluation plans all using the comprehensive school health framework.

A new *Teen After School Program* was launched for intermediate and senior high students. Healthy snacks and activities for teens of all physical abilities were provided, including Walk & Run Club, Aquatic Bootcamp, Learn to Skate, Land Circuit Training, 5 Pin Bowling, Aquatic Circuit Training, Roller Hockey, and Lifesaving Training. The program was made available free of charge, through a partnership with go!PEI and the City of Summerside's Credit Union Place.



New Brunswick

The New Brunswick Healthy Learners in School Program, initiated in 2000, is a Public Health program delivered by the Regional Health Authorities. It is aimed at promoting student health and wellness through the creation of healthy, safe, and supportive physical and social environments. Public Health Nurses and Dietitians work with school districts to implement comprehensive school health initiatives with the support of Health Advisory Committees that include educators, parents and community groups, and program representatives. Their efforts are supported by the Department of Social Development (DSD) which champions New Brunswick's Wellness Strategy and focuses on supporting physical activity, healthy eating, tobacco free living, and mental fitness and resilience in schools, communities, workplaces, and homes. The Department also undertakes a multi-year data collection initiative, which monitors progress and includes support for schools in efforts to use their own results to take action on wellness. DSD funds two School Wellness Consultants who collaborate with and facilitate the work of education wellness champions. They support comprehensive school health approaches through the distribution of grants and resources, providing training to school and district employees, provision of a School Wellness Newsletter, and in connecting schools to other resources in their communities such as Wellness Networks. The Department of Education and Early Childhood Development (EECD) reflects a comprehensive school health approach through policy, curriculum planning and delivery, education support services, and commitment to community schools.

Leadership

- Following a successful pilot the **Premier's Challenge**, a partnership with Active at School and Canadian Tire Corp., was implemented province-wide by EECD. The goal is to ensure children across the province have one hour of physical activity before, during, or after school every day. In 2014-2015 a total of 140 schools (94 Anglophone, 41 Francophone, and 5 First Nations) registered for the Challenge. To streamline the process, applications were accepted in conjunction with the School Wellness Grants Application Process.
- New Brunswick's Wellness Strategy 2014-2021, The Heart of our Future, was released in August 2014. It provides a framework that enables communities, schools, workplaces, organizations, families, or individuals to see how their goals, activities, or mandates are supported by improved wellness and how they can contribute to enhancing wellness within the province. A key recommendation from the evaluation was to broaden the focus of the Wellness Strategy, to encourage action on all the dimensions of wellness and on all the determinants of health rather than limiting it through the four previous healthy lifestyle goals. This renewed focus recognizes that in order to achieve sustained population level improvements on wellness, the goals must be broader in scope than only addressing healthy lifestyle behaviours. The Wellness Strategy focuses on two key goals:
 - to increase the number of New Brunswickers with the capacity to support healthy development and wellness, and
 - to increase the number of settings with conditions to support wellness.

Knowledge Development and Exchange

- DSD continues to partner with the NB Health Council on implementation of the **Student Wellness Survey** initiative. Following two years of data collection, the focus of effort this year was on knowledge translation and mobilization, supporting schools as well as numerous community organizations and health professionals to understand and act on the data. These efforts are contributing to a common picture and language among all partners, including schools, which is helping to bridge school and community contexts and actions.
- **NB PLAYS!** is an after school initiative for children and youth ages 5 to 19 led by Recreation NB in collaboration with Department of Social Development. It highlights positive mental health, physical activity, healthy eating, community strengths, and learning experiences as key elements in balanced after school programming. After school has been identified as a critical time frame to promote health and wellness among children and youth. NB PLAYS! is supported by a broad based advisory committee composed of representatives from government, non-profit and private sectors, as well as First Nation organizations and includes champions of recreation, health, wellness, education, quality childcare, parks, and sport. This year the NB PLAYS! Playbook was launched – a comprehensive resource for front line leaders of after school hours programs.
- Development of a new curriculum for Grade 3-5 Healthy Living/Career Planning is underway. This revised curriculum for the Anglophone sector will incorporate outcomes from the current separate Health Curriculum and the Personal Development and Career planning curriculum. This curriculum maintains the commitment of the Department of Education and Early Childhood Development to comprehensive school health and to the Comprehensive and Developmental Guidance Program.

Capacity Building

- The **Wellness Movement** is a multi-year social marketing initiative in support of the Wellness Strategy. This year the theme is "Start your Story" which features wellness stories of individuals, families, community groups, schools, and workplaces from all across our province shared through various promotional channels including television, The Wellness Movement website, digital displays online, as well as on social media. School stories can be viewed at <http://www.wellnessnb.ca/start-your-story/#>
- In January 2015, the **Take Action on Tobacco Use Grant Program** was launched. Grants support community-led initiatives to increase tobacco-free living and strengthen community action with an emphasis on youth-led initiatives, partnerships, and comprehensive actions. Eligible applicants (including schools) can receive up to \$5,000 in grant funding for tobacco-free living projects.
- DSD hosts **annual Sharing Circles** to engage First Nation communities and Aboriginal organizations in asset-based community development approach to share promising wellness practices across communities. Four out of nine First Nation schools participated in this year's Sharing Circle where school initiatives and lessons learned were shared with representatives from other communities.
- Four schools from one School District have participated in PHE Canada's Pilot Project – Health Promoting Schools. The purpose of this project is to assist schools establish a more sustainable framework to guide their healthy school community efforts by using a process that will help them develop or enhance a comprehensive school health vision, build an environment for collaborative learning and support, as well as promote healthy schools in their jurisdiction. The initiative utilized existing tools and resources already in use in NB including Student Wellness Survey data and JCSH Healthy School Planner.

Ontario

Promoting well-being is one of four goals in Ontario's renewed vision for education, Achieving Excellence. Under this goal, Ontario aims for all children and students to develop enhanced mental and physical health, a positive sense of self and belonging, and the skills to make positive choices. These objectives emphasize the need to focus on the whole child and student – their cognitive, emotional, social, and physical development. Elevating well-being as a goal for education recognizes its fundamental importance to learners and their futures.

Leadership

- In November 2014, Ontario released a revised and expanded version of its healthy schools framework, Foundations for a Healthy School, as a result of research and input from education and school-based health experts and multiple ministries. The Foundations for a Healthy School resource supports the integration of healthy schools policies, programs, and initiatives into school and school board planning and implementation processes.
 - The resource provides sample strategies and activities to foster a positive school climate, take an integrated approach, and address six curriculum-linked, health-related topics: Physical Activity; Healthy Eating; Personal Safety and Injury Prevention; Growth and Development; Mental Health; and Substance Use, Addictions, and Related Behaviours.
 - The new resource closely aligns with the components and indicators of school effectiveness from the K-12 School Effectiveness Framework by including five interconnected areas: Curriculum, Teaching, and Learning; School and Classroom Leadership; Student Engagement; Social and Physical Environments; and Home, School, and Community Partnerships.

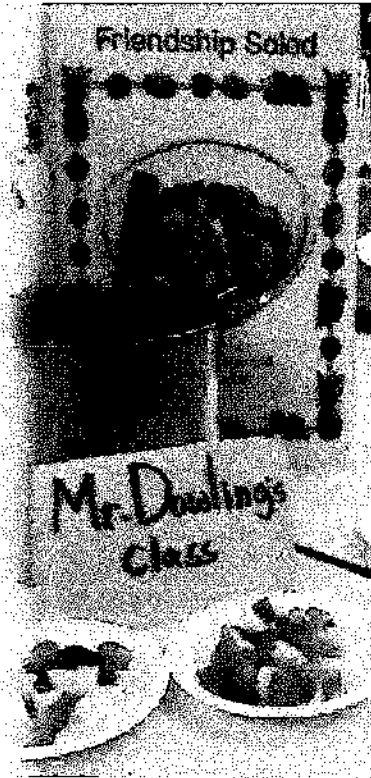
- The Ministry of Education and the Ministry of Tourism, Culture and Sport along with other partners established the Pan Am/Parapan Am Kids (PPAKids) initiative to encourage participation in a variety of sports/parasports and recreational and cultural activities inspired by the 2015 Pan Am/Parapan Am Games over the 2013-14 and 2014-15 school years.
- As part of the Local Food Act, 2013, the Ontario Minister of Agriculture, Food and Rural Affairs established aspirational goals to help improve food literacy in respect of local food, as well as access to and use of local food.
 - In 2014, Ontario Agri-food Education Inc. Teacher Ambassadors™ provided free agriculture and food themed lessons, student tours and educational exhibits and workshops across Ontario. The interactive lessons helped encourage students and teachers to think critically about agri-food issues, stimulated interest in agricultural innovations and encouraged careers in the agri-food sector.
 - The Northern Fruit and Vegetable Program (NFVP), led by the Ontario Ministry of Health and Long-Term Care, increases awareness and consumption of fruit and vegetables for elementary and intermediate school-aged children in three northern regions by providing no cost fresh fruit and vegetables in combination with healthy eating and physical activity education. The NFVP was expanded in 2014 to support Ontario's Healthy Kids Strategy, doubling the program's reach to over 190 schools, including First Nations schools on-reserve along the James Bay Coast.
- Through Ontario's Equity and Inclusive Education Strategy (2009), schools and school boards are identifying and addressing discriminatory biases and systemic barriers to help foster healthy, safe, equitable and inclusive social environments that support the success and well-being of all students.
 - Implementation of the Strategy is guided by Ministry-developed resources including Equity and Inclusive Education in Ontario Schools: Guidelines for Policy Development and Implementation and a reflective tool entitled How do we know we are Making a Difference?, which were released in 2014, as well as a range of other tools and resources developed through diverse stakeholder partners.

Knowledge Development and Exchange

- In February 2015, the Ministry of Education released The Ontario Curriculum, Grades 1-8: Health and Physical Education, 2015 and The Ontario Curriculum, Grades 9 to 12: Health and Physical Education, 2015. The Ministry also released materials to support parents in understanding the revised elementary and secondary school curriculum. Implementation of the curriculum will begin in September 2015.
- In March 2015, the Ministry of Education held meetings with stakeholders to discuss a review conducted by the Ophea on how prevalent medical conditions are managed in schools.
 - As a result of discussions, Ontario convened a Prevalent Medical Conditions Committee consisting of members from disease-based charities, all four publicly funded systems of education, and the Ministries of Education and Health and Long-Term Care to provide input on the development of an overarching provincial approach to prevalent medical conditions in schools.

Capacity Building

- In September 2014, Ontario announced the communities selected to participate in the Healthy Kids Community Challenge, a program under Ontario's Healthy Kids Strategy that will provide resources including funding, training, guidance and social

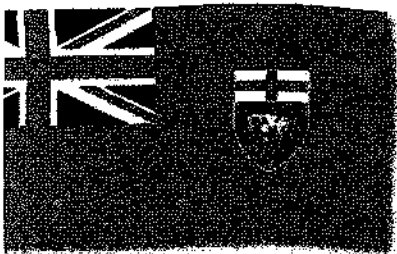


marketing tools to help promote healthy eating, physical activity and healthy lifestyle choices for children. The program will involve collaboration with local partners, including schools.

- In November 2014, the Ontario Software Acquisition Program Advisory Committee launched a Digital Citizenship resource to support educators as they guide students in a digital world.
 - During the 2014-2015 school year, e-Learning Ontario and 21st Century Teaching and Learning supported the well-being of Ontario youth by facilitating sessions for classroom educators and school leaders about the responsibilities of a digital citizen through the Digital Citizenship resource.
- In November 2014, Ontario announced a partnership with the **ACTIVE AT SCHOOL** initiative and the Ontario Physical and Health Education Association to help provide access and opportunity for students to get 60 minutes of physical activity connected to the school day.
 - The partnership has worked to achieve this goal by creating a Physical Activity Advisory Committee; developing a formal recognition program, Heroes of Play; and establishing pilot sites through a Healthy Schools Certification initiative to help support school communities in joint planning, action and celebration.
- The Student Nutrition Program, led by Ontario's Ministry of Children and Youth Services, helps provide nutritious breakfasts, lunches and snacks in schools and community locations across Ontario to support learning and healthy child and youth development.
 - As part of the Poverty Reduction Strategy (2014), an additional \$10.3M was invested in the Student Nutrition Program, bringing the province's total annual funding to over \$31M. The new investment is supporting an expansion of 340 new breakfast programs in higher needs schools and enhancements to existing programs.
 - The Ministry of Children and Youth Services is working with First Nations partners to develop and implement Student Nutrition Programs in on-reserve educational settings
- The Ministry of Children and Youth Services' Youth Opportunities Fund (YOF) provides grants and capacity building supports to grassroots, youth-led initiatives and community-based organizations to support youth (aged 12-25) who face barriers to economic and social well-being.
 - In the 2014-15 school year, the YOF funded the grassroots innovation project Toronto's Success Beyond Limits (SBL) among other projects. SBL brings social, recreational and academic supports to middle-school youth in order to better prepare them for high school and connect them to opportunities that will foster new skills and relationships and expand their horizons.

Manitoba

First introduced in 2000, Healthy Schools is Manitoba's provincial school health initiative promoting the physical, emotional, and social health of school communities. The Healthy Schools Initiative recognizes that good health is important for learning and that schools are uniquely positioned to have a positive influence on the health of children, youth, and their families. Healthy Schools reflects the province's commitment to support progress towards enhanced health and education outcomes for all students. Healthy Schools is a partnership of Manitoba Health, Healthy Living and Seniors, Manitoba Education and Advanced Learning, and Children and Youth Opportunities – Healthy Child Manitoba.

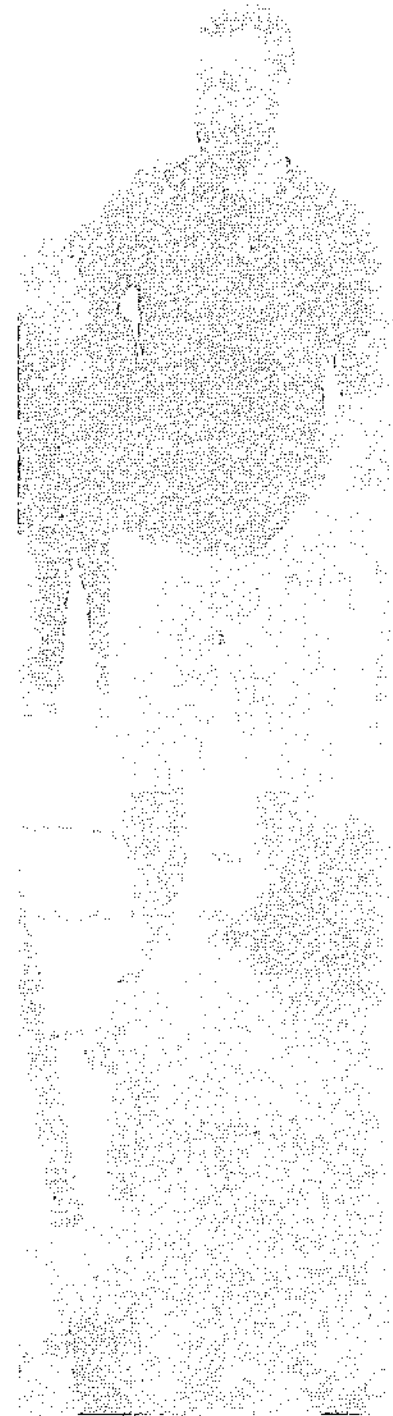


Leadership

- In February 2015, the Manitoba High Schools Athletic Association passed a ground-breaking policy allowing transgender student athletes to participate in gender-separated interscholastic sports activities in accordance with their gender identity.
- Manitoba's Policy for Recreation Opportunities, a new provincial recreation policy, was released in February 2015 and reflects the shared values expressed by stakeholders, including the importance of recreation and recreation leadership, sustainable investment, and accessibility for all.
- In February 2015, the Manitoba government released Starting Early, Starting Strong: Manitoba's Five-Year Plan for Early Childhood Development (ECD). Two sets of province-wide indicator data serve as key "check points" to show us how our children are doing at birth and as they start school in kindergarten. The plan commits to supporting sustainable and strong communities through investments in community capacity building and training, partnership development, public education, and knowledge sharing.
- Winnipeg, Manitoba hosted OUTShine 2015, Egale Canada's 2nd National Gay-Straight Alliance (GSA) Summit, from May 15 to 17, 2015. About 500 youth and educators gathered to discuss LGBTQ inclusion in schools, creating and sustaining GSAs, and sharing LGBTQ and Allied experiences.
- 2015 marked the 10th year of delivering the Low Cost Bike Helmet Initiative and a milestone in delivering over 100,000 helmets to children, youth, and parents across Manitoba. To celebrate this occasion, a public event including a Guinness World Record Attempt was held in June 2015.

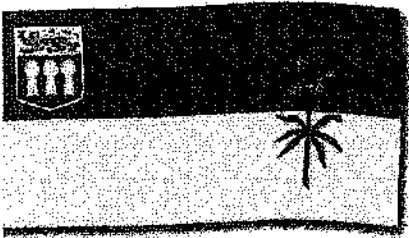
Knowledge Development and Exchange

- Manitoba hosted the first Provincial Physical Literacy Conference, Physical Literacy: the Gateway to Active Participation, in March 2015 in Winnipeg with over 370 delegates attending from across the health, education, recreation, sport, and early childhood sectors.
- The Manitoba Youth Health Survey 2012-2013 Report was released in November 2014, providing provincial data on the health behaviours of Manitoba youth. The survey, conducted by Regional Health Authorities with 64,000 Grades 7-12 students from 476 schools, looked at physical activity, healthy eating, body mass index, tobacco use, alcohol and drug use, school and community connectedness, hopelessness and mental wellbeing, as well as sun/UV safety, bullying, injury prevention, and healthy sexuality.
- Manitoba introduced the Best Practices in School-based Suicide Prevention: A Comprehensive Approach, a guide intended to help school administrators and their partners develop comprehensive planning for suicide prevention and postvention support. It includes checklists, sample policies, self-assessment tools and introduces a model for understanding prevention efforts from universal mental health promotion to targeted approaches.
- Manitoba released the Moving Forward with School Nutrition Guidelines to replace the 2006 Manitoba School Nutrition Handbook: Getting Started with Guidelines and Policies. It is divided into six areas of focus where schools often provide food for students and is designed to assist schools as they make plans to improve school nutrition environments.
- Healthy Schools continued to keep school communities up to date on the latest news via the Healthy Schools eNews, a free electronic subscription service.



Capacity Building

- Manitoba provided annual funding through Healthy Schools Grant to school divisions, Independent, and First Nations schools to assist with Healthy Schools plans and priorities as they build healthy school communities.
- The Manitoba Association of School Superintendents and Manitoba Education and Advanced Learning, in collaboration with a number of educational partner organizations, held the Mental Health and Wellness: Education for Action Conference in Winnipeg November 13-14, 2014 to increase understanding amongst educators, health partners, and students.
- The Winnipeg Jets True North Foundation's Project 11 was inspired and created in honor of Rick Rypien #11, a hockey player who suffered from clinical depression and died by suicide. It was developed locally to support students in Grades 5-8 with virtual tutorials on positive mental health in English Language Arts and Physical Education/Health Education. About 2000 Grades 5-6 students participated in a pilot with support from Healthy Child Manitoba.
- Manitoba continued to support youth-friendly primary health care through its network of 36 Teen Clinics in the province, 19 of which are located in Manitoba schools. Teen Clinics provide youth 13+ with accessible, confidential services and operate from a pro-choice and harm reduction perspective. The province funded 10 Teen Clinic programs directly and provides resources and professional support to the entire network.
- Manitoba increased support to the Child Nutrition Council of Manitoba to expand nourishment programs, particularly in high-needs schools.



Saskatchewan

In Saskatchewan, the Ministries of Health and Education, along with other provincial ministries and organizations, work together to promote the health and well-being of children and youth. Using a Comprehensive School Community Health approach to guide and coordinate government actions, Saskatchewan's priorities include ensuring equitable outcomes and improved student achievement for First Nations and Métis students; supporting safe, caring and respectful learning environments; promoting mental health; and consulting with stakeholders.

Leadership

- The Ministry of Education committed to the collaboration with school divisions and First Nation education jurisdictions to develop processes and resources to respond to Tell Them From Me (TTFM) data and improve the engagement and achievement of all Saskatchewan students.
- The Government of Saskatchewan committed to ensuring that Treaty education is mandatory in K-12 curricula. To support this mandate, the Office of the Treaty Commissioner was contracted to develop instructional resources to create awareness and understanding that all Saskatchewan residents are beneficiaries of Treaties.
- Working Together for Change: A 10 Year Mental Health and Addictions Action Plan for Saskatchewan was released in December 2014. The report was a culmination of extensive public consultations which took place between August 2013 and April 2014. The Government has endorsed the Mental Health and Addictions Action Plan which will guide efforts to improve mental health and addictions service provision over the next 10 years.

Knowledge Development and Exchange

- Student First advisors travelled across the province in 2013-2014, meeting with students, parents/caregivers, and teachers at 120 engagement sessions. The engagement process was based on the principle that every student wants to achieve, every teacher wants each student to achieve, and the role of the education system is to support them with that goal. Four themes were reported and they include
 - Shared Responsibility
 - Relationships
 - Engaging the Student/ Learner
 - Learning Environment and Student/Teacher Supports.
- View and Vote 5 is an educational program for schools that encourages young people to think critically about tobacco and make healthier choices. The program gives students in Grades 6 to 12 an opportunity to view 12 of the world's best anti-tobacco TV ads. Teachers guide students as they watch the ads, and encourage them to discuss the consequences of using tobacco. Students select the ad they feel is the most effective in helping them stay tobacco-free or make them think about quitting. Over 3200 students across Saskatchewan participated in View and Vote 5 in 2014. Participating teachers were also given an opportunity to win one of six classroom prizes to support Comprehensive School Community Health.
- Smokestream is a website for Saskatchewan teens and pre-teens to talk about smoking and voice their opinions with each other, with special focus on ages 11-14, the group most likely to experiment with tobacco. Participants are encouraged to invite their friends to come to the website and join in on the conversation. An advertising campaign featuring the words and voices of Saskatchewan youth was launched in January 2013 and re-ran in early 2015.

Capacity Building

- Saskatchewan's Comprehensive School Community Health framework was updated to reflect the importance of engaging family, of a more explicit focus on First Nations and Métis perspectives, and of the significance of policy and procedures in creating safe and healthy learning environments.
- A Grade 6 Sample Unit on Tobacco was developed collaboratively by the Saskatchewan Ministries of Health and Education. This online resource includes current information about tobacco, related topics, and provides learning activities for Saskatchewan teachers to use in classroom settings. The key objective of this sample unit is to introduce the health and social issues related to tobacco for youth. Complete with links to other resources, this online unit promotes healthy lifestyles and encourages youth to further explore health behaviours. This resource is designed to be used after outcomes 6.1 and 6.8 in the Grade 6 provincial health education curriculum have been addressed.
- The Government of Saskatchewan has updated the Healthy Foods For My School resource in collaboration with the Public Health Nutritionists of Saskatchewan Working Group. This guide helps schools choose and provide healthy food and beverage options for students. This resource is used to assist in reading food labels and selecting foods and beverages to be served or sold in schools in Saskatchewan.

Alberta

The Alberta government is committed to supporting healthy Albertans by encouraging schools to adopt a comprehensive school health approach to increase levels of physical activity, healthy eating and positive mental health. Since 2000, Alberta school communities have been supported through joint initiatives by Alberta Education and Alberta Health to improve student health and learning outcomes. New strategic directions and legislation in Alberta continues to strengthen opportunities for supporting student success and well-being in healthy school communities.

Leadership

- In support of [Alberta's Strategic Approach to Wellness](#), Alberta Health has been working cross ministry with over 15 other ministries to lead a range of activities designed to support the development of a provincial Wellness Action Plan. The cross ministry activities included the development of a whole of government outcome map for wellness, review of all government expenditures on the wellness line of business, development of recommendations for future directions and preparation for public engagement on wellness.
- Alberta Education is working with education partners on the development of future programs of study. [Curriculum Development Prototyping](#) ended in January 2015, which provided publicly funded school authorities and other educational partners the opportunity to contribute earlier in the development process. The process used by provincial partners and the ideas generated from Prototyping will be used by the Ministry to help inform future provincial programs of study development.
- Alberta Education's [High School Completion Strategic Framework](#) addresses the challenges students face in completing high school and helps to ensure all students are given opportunities to succeed. One initiative of this framework is the [Moving Forward with High School Redesign](#). This is an innovative, grassroots approach that supports high schools to focus on research and 'next practice' thinking when implementing strategies and approaches aimed at transforming the high-school experience for students and teachers. This initiative supports changes to school structure, culture, pedagogy and leadership.

Knowledge Development and Exchange

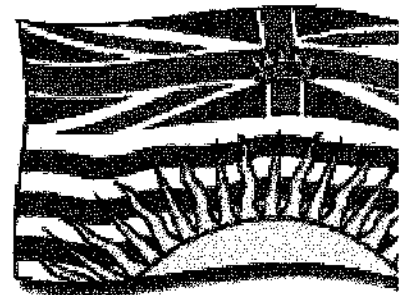
- The Healthy Active School Symposia (HASS), coordinated by Ever Active Schools (EAS), provides a platform for relationships to be formed between teachers, students, parents, and community partners. In 2014, EAS hosted 12 HASS events in communities across Alberta engaging 267 schools in 55 of 61 school authorities. The focus of this year's HASS events was to foster student voice and increase student involvement in creating healthy school communities.
- A preconference session focused on mental health was hosted by Alberta School Boards Association (ASBA) in partnership with EAS at the annual Shaping the Future Conference. This session brought school trustees and other invited guests from health and education together to consider a more collaborative approach to improve student mental health in school communities. A student health and well-being task force has been established by ASBA to develop initiatives to support the health of students.
- Alberta's First Nations Communities continue to implement resiliency strategies in school communities through the implementation of a comprehensive school health approach with support from EAS. For example, Kainai Board of Education demonstrated further commitment to student health and learning through the employment of wellness coordinators for school communities. These coordinators will engage with community stakeholder to produce culturally relevant and locally sustained initiatives in support of healthier school communities

Capacity Building

- The Mental Health Capacity Building in Schools Initiative (MHCBI) works to strengthen the capacity of schools and communities to create healthy cultures, promote mental health and wellness in its children, youth and families using schools as hubs. Working together to implement integrated mental health promotion, prevention, and early intervention requires different approaches based on the unique needs of individual communities and schools. MHCBI projects were initially funded in 2006, beginning with five pilot sites and have now grown to include 70 communities throughout Alberta. MHCBI is led by Alberta Health Services in collaboration with Alberta Education, and funded through grants from Alberta Health.
- The Alberta Healthy School Community Wellness Fund (Wellness Fund) was created in 2007, and has managed 21 different grant calls, supporting 274 school community projects to infuse wellness into the culture of their schools through the implementation of a comprehensive school health approach. Supports have been provided at the district level to 56 of Alberta's 61 public, separate and Francophone school authorities. The Wellness Fund continues to gather data from schools implementing a comprehensive school health approach to inform decisions related to improved student health and learning outcomes.
- The Healthy School Communities Award was held on January 29, 2015 at the annual Shaping the Future Conference. The awards celebrated individual, school, school district and community champions who work together to achieve positive health outcomes for children and youth.

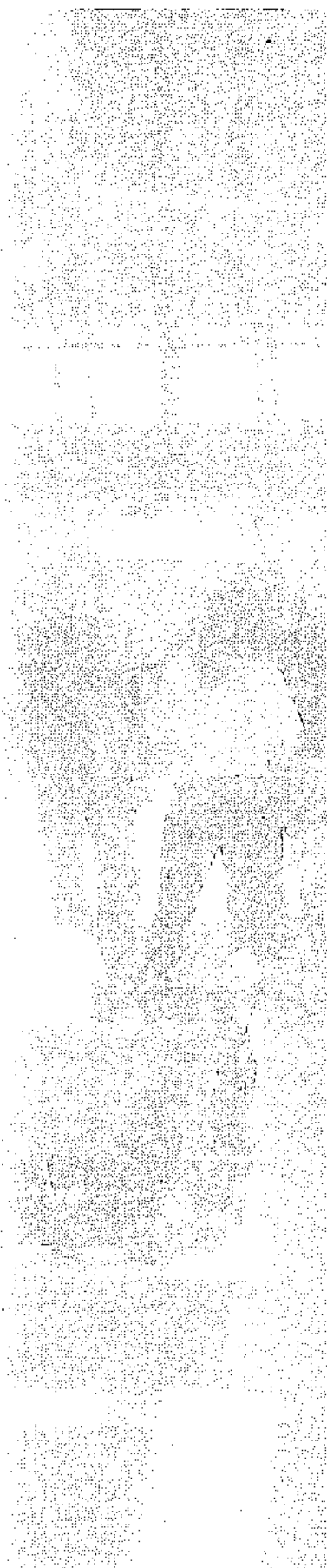
British Columbia

Within British Columbia, many schools, districts, and community partners have developed innovative ways to support the health and learning of students. Introduced in 2011, Healthy Schools BC (HSBC) is a key initiative under the Province's broader health promotion strategy. HSBC supports health, education, students, and community partners to work together to create healthier schools using a Comprehensive School Health (CSH) approach. Strengthened health-education-community partnerships, meaningful student engagement, coordination of existing school-based healthy living programs, and new tools and resources combine to support improvements in students' health and learning. The initiative supports the long term goals of the BC Education Plan and BC's Guiding Framework for Public Health. HSBC is a partnership of the ministries of Health and Education, DASH BC, health authorities, education partners, and other key stakeholders.



Leadership

- Over 10,000 educators and community partners received training to identify and address threats as a part of the ERASE Bullying strategy. Safe School Coordinators responded to more than 500 student safety issues through an anonymous online student reporting tool. ERASE Student Advisory released social media guidelines and are developing a positive mental health resource for elementary students.
- The ministries of Health and Education worked together to facilitate cross-sector input on the draft K-12 Physical and Health Education curriculum.
- Students from the BC Student Healthy Living Network developed and implemented student-led healthy school initiatives addressing a range of topics, including positive mental health, physical activity, and healthy eating.
- Lessons learned from the After School Sport and Arts Initiative (ASSAI) were presented at the 2014 Global Summit on the Physical Activity of Children and ASSAI's adapted



pilot program for children with disabilities was presented at the International Physical Literacy Conference 2015.

- The McConnell Foundation announced the creation of a Social Innovation Lab, which will focus on schools as a setting for advancing child and youth wellbeing, with BC being the first province to launch.
- The BC School Centred Mental Health Coalition (BCSCMHC) finalized a strategic plan which provides a 5 year vision for promoting student mental health, connectedness, and engagement in school.
- Provincial standards, guidelines, training materials and supports were developed to support safe diabetes management and enable training and monitoring school staff to administer insulin for students not yet independent in the task. Glucagon administration training was provided and emergency care plans for students with type 1 diabetes were developed.

Knowledge Development and Exchange

- DASH BC hosted the 8th Annual Healthy Schools Leadership Symposium in May 2014. Headlined by a keynote from Paul Born of the Tamarack Institute, the theme of this year's Symposium was collective impact. In November 2014, the Healthy Schools BC Community Leadership Workshop provided a unique opportunity for community-based organizations involved in healthy schools work to explore opportunities for collaboration, innovation, and integration.
- Following the release of the provincial results of the 2013 BC Adolescent Health Survey, which was completed by almost 30,000 youth, the McCreary Centre Society released 16 regional reports showcasing the health profile, risk and protective factors for youth age 12 to 19.
- The School Connectedness Capacity Building Initiative provided grants to four schools and two districts with demonstrated success in improving school connectedness, supporting them to share their expertise with other school communities.
- The BCSCMHC, in partnership with BC Mental Health and Substance Use Services, co-led the 5th annual Summer Institute for Promoting Mental Health in BC Schools.
- A two year evaluation of a full-day Nature Kindergarten program was initiated. Preliminary findings showed a beneficial effect on children's motor skills, self-control, social skills, and psychological adjustment.
- The Ministry of Health, in partnership with the BC Injury Research and Prevention Unit and Child Health BC developed the Concussion Awareness Training Tool, which supports educators, school support staff, parents, coaches and health professionals to prevent, assess and manage concussions.
- A two year evaluation of the Tools of the Mind program was initiated. Preliminary evaluation demonstrated positive results on objective measures of academic performance and students' excitement to learn, joy in coming to school, and social-emotional development.

Capacity Building

- HSBC provided 17 grants to school districts to support healthy schools planning and action with health sector partners. In addition, 305 Healthy Schools Network (HSN) grants were provided to schools to support healthy living initiatives with a focus on engaging students. Training was provided to HSN Leaders on how to coach and mentor new HSN participants.

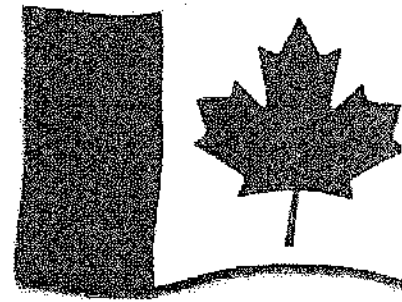
- DASH BC continued train-the-trainer style HSBC learning sessions across all regional health authorities. The new Cross-Sector Engagement Rubric was created as a tool for all healthy schools stakeholders to support relationship building across sectors.
- The ASSAI funded sport, physical activity, arts and culture programs in 181 schools in 14 districts. This included enhanced funding to support new and/or expanded adapted programming for children with disabilities.
- The BC Friends for Life online parent website was enhanced to include video vignettes of FRIENDS being used at home with BC children and youth and their parents.
- BC School Fruit and Vegetable Nutritional Program delivered fresh BC fruit and vegetables and learning opportunities to nearly 500,000 students every second week throughout the school year, reaching 90% of public and First Nations schools.
- The Fresh to You Fundraiser, which sells bundles of fruits and vegetables with 40% profit going back to the school, was launched with 60 schools participating in the inaugural delivery in May 2015.
- Farm to School was expanded to over 30 new schools, focusing on schools with vulnerable students. New Farm to School Regional Hubs were established, helping inspire regional connections between schools, farms and community partners.

Government of Canada

The Federal Government is represented by the Public Health Agency of Canada and supports the JCSH work in an advisory and funding capacity.

Leadership

- In November 2014, the Canadian Institutes of Health Research Institute of Human Development, Child and Youth Health hosted the first Innovating Child and Family Health Conference. Close to two hundred invited researchers, clinicians, patients, families and caregivers, hospital and community foundations, philanthropists, private sector representatives, politicians and key opinion leaders joined together in Ottawa, Ontario to debate, discuss and network in hopes of building a renewed vision for advancing the health and well-being of Canadian children and families into the 21st century.
- In February 2015, the Health Portfolio announced up to \$10 million in annual funding to support victims of violence from a health perspective. The Public Health Agency of Canada will administer \$7 million annually to improve the public health response to violence and support community programs. Health Canada will administer up to \$3 million annually to enhance access to mental health counselling and improve services for First Nations and Inuit victims of family violence and their children.
- The federal and provincial/territorial governments continue to work together to implement the Canadian Sport Policy (CSP). All governments have prepared jurisdiction-specific action plans for implementation of the CSP.
- The Governor General of Canada has proclaimed that 2015 is the Year of Sport in Canada. It is a proactive pan-Canadian communications initiative to celebrate the role that sport plays in our country and to encourage Canadians to participate in and seek the benefits of sport.
- The RCMP hosted two RCMPTalks sessions in November 2014 & March 2015 on Bullying and Cyberbullying. "RCMPTalks" is a series of live, interactive videoconferences in schools across the country. Each RCMPTalks conversation



allows students from up to six different Canadian classrooms per session to hold a discussion via videoconference and social media, and to pose questions to designated guests during a 90 minute live session.

- The National Youth Advisory Committee (NYAC) (Sept. 2014 to June 2015) discusses important youth issues and assists in the development of strategies to prevent youth crime and victimization. Through the NYAC, the RCMP and its partners are able to learn about new trends happening in various communities and to identify any gaps in education and awareness resources.
- The Public Health Agency of Canada collaborated with high profile partners to launch The Play Exchange (TPX), a national competition seeking out transformative ideas to promote healthier active living. Canadians had the opportunity to vote on their favourite idea, and finalists were profiled nationally on a CBC special. The winner, Trotibus Walking School Bus, is a pedestrian bus service, providing elementary school children with a safe and fun way to get to school every day all the while being active. TPX is an innovative example of shared leadership between various sectors, including the private sector, with the intent to advance multi-sectoral action on healthy living. Through initiatives like TPX, the Agency has been successful brokering new partnerships and broadening its stakeholder base.

Knowledge Development and Exchange

- The Health Behaviour in School-aged Children (HBSC) data collection for 2013/14 was completed. The HBSC study is a cross-national, school-based survey conducted by an international network of research teams in collaboration with the World Health Organization (WHO) Regional Office for Europe. Primarily funded by the Public Health Agency of Canada, it is administered in Canada every four years by the HBSC Canada research team at Queen's University, as well as in 42 other countries in Europe and North America.
- Health Canada's 2014-15 Preventing Drug Abuse campaign focused on raising the awareness with parents of the harmful health effects of marijuana use specifically on the developing brain of teens, and the harmful effects of teens abusing prescription drugs. It provided parents with information and tools to talk with their teens about these issues.
- The Public Health Agency of Canada's Canadian Best Practices Portal provides a comprehensive repository of community and population health interventions, strategies, guidance, systematic reviews and data relevant to chronic disease prevention and health promotion. In addition, the Portal includes resources for policy making and professional development in Public Health. School Health has been a Public Health Topic on the Portal, the data and guidance sections of this topic feature several of the Pan-Canadian Joint Consortium for School Health documents.
- The Public Health Agency of Canada released five fact sheets on key determinants of sexually transmitted and blood borne infections (STBBIs) among street-involved youth. The fact sheets provide considerations for community organizations, public health professionals and federal, provincial and territorial governments of ways to address determinants of vulnerability to and resilience against STBBIs among street-involved youth in Canada. The fact sheets in the series include: mental health and mental illness, unstable housing and homelessness, education and employment, experiences with the criminal justice system, and access to health services.
- The Public Health Agency of Canada developed and launched a pilot antimicrobial resistance awareness campaign focusing on improving knowledge and awareness of responsible antibiotic use and good infection prevention and control behaviours

among Canadians. The Agency also developed an infographic specifically for youth entitled *Germs & Antibiotics* to help teach youth between the ages of 8 and 12 about antibiotics, antibiotic resistance, and good infection prevention and control behaviours.

- The Public Health Agency of Canada's Innovation Strategy continued to provide funding using a population health intervention research approach for the implementation and evaluation of evidence based programs for children, youth, and their families to achieve healthier weights and promote mental well-being in communities. This included funding for the Fourth R which is a comprehensive school-based prevention program for younger adolescents, parents, teachers and teacher candidates. The Fourth R's programming with Aboriginal youth was associated with positive impacts on relationships, confidence and school success. Other Innovation Strategy initiatives engaged schools in community-based approaches to food security such as active educational games developed by youth for youth, promoting traditional foods through school curriculum, and growing gardens at school.
- In April 2014, the Canadian Institutes of Health Research Institute of Human Development, Child and Youth Health organized a Café Scientifique in Fredericton, New Brunswick about child and youth mental health. The purpose of a Café Scientifique is to provide insight into health-related issues of popular interest to the general public, and in turn provoke questions and provide answers through the interaction between the public and experts in a given field.
- CIHR also helped support the WITS Program (Walk away, Ignore, Talk it out, Seek help), an anti-bullying program designed to support children who are responsive and proactive when they seek help for bullying which is being implemented by 290 schools across the country.
- The Canadian Institute for Health Information has prepared Children Vulnerable in Areas of Early Development: A Determinant of Child Health which looks at how Canada measures the health and well-being of 5-year-olds. An overview of provincial and territorial initiatives to improve early child development is also included. Children who are exposed to optimal environments early in life have the best opportunities to grow up healthy and happy. Understanding how children are developing allows policy-makers to make informed decisions about investments in programs and policies that support children and families.
- Every year, hundreds of thousands of children and youth in Canada are injured at home, school and play. In 2013-2014, around 17,500 of them were hospitalized for injuries, and approximately 3,000 of these hospitalizations were for an intentional injury—self-inflicted or caused by others. Info sheets and data tables on this issue can be found on the website for the Canadian Institute for Health Information at *Self Harm and Assault: A Closer Look at Children and Youth*.
- The Centre for Youth Crime Prevention (CYCP) provides youth, adults working with youth and police officers with fact sheets, ready-to-use presentation resources, and best practices on various youth crime prevention issues. The CYCP includes the information and engagement tools required to influence youth behaviour, notably: factual information, opportunities for skill building and information that motivates youth to take action.

Capacity Building

- The Public Health Agency of Canada coordinates and leads the federal Family Violence Initiative, which connects the work of 15 federal departments to prevent and respond to family violence. On behalf of the Family Violence Initiative, the Agency hosts the

Stop Family Violence webpages. The pages provide information and resources for professionals and the public, including addressing risk factors for youth violence and promoting healthy relationships for youth.

- The Justice Canada component of the federal Family Violence Initiative has funded two projects that will address the issue of forced marriages in Canada as a form of family violence in a school setting. The first project involves the delivery of a high school curriculum in Toronto on issues of citizenship, identity and youth agency in a multicultural context, including issues such as forced marriage. The second project involves the development of legal information on forced marriage and to raise awareness among students attending francophone schools in Ottawa.
- In September, 2014, the Canadian Institutes of Health Research Institute of Human Development, Child and Youth Health Talks launched its first video competition, a unique funding opportunity inviting researchers, knowledge-users to produce a short video to share their research and ideas in the area of reproductive, child and youth health. The objective of this competition is to encourage the production of videos that present evidence-based research to a lay audience and that incorporate a message designed to have a positive impact on the health of children, youth and families.

Moving Forward

The Pan-Canadian Joint Consortium for School Health celebrates another year of commitment to all the initiatives across the country building healthy school communities and enhancing alignment between health and education. In 2015, we are particularly pleased to celebrate a renewed mandate and commitment to school health. As we move through these next five years, we maintain our commitment to between-sector and cross-jurisdictional collaboration. As well, we will further develop our partnerships to serve as a bridge for researchers, policymakers, and practitioners to work across the health and education sectors, to create and disseminate tools that foster awareness, and to facilitate planning and action for school health improvements in Canada.

We continue to emphasize three key areas of activity – leadership, knowledge development and exchange, and capacity building – to further this country's dedication to the best health and education for all our children and youth. In addition, the JCSH continues working to increase its effectiveness and national presence with partners working in school health both within Canada and around the world.

As this annual report goes to print, the Consortium works towards evaluation of the revised Healthy School Planner, development of companion learning pieces for our toolkits, and next research and dissemination pieces for our work on the Core Indicators and Measures of Student Achievement and Comprehensive School health.

These are just a few examples of how the JCSH supports and influences a policy- and practice-informed research agenda on comprehensive school health. We look forward to another year of progress with our partners, in all our member jurisdictions.

Appendix A: Agreement

Pan-Canadian Joint Consortium for School Health Agreement 2010-2015

Background

WHEREAS in 2005, provincial and territorial ministers of Education and provincial and territorial ministers of Health and the federal Minister of Health established the Pan-Canadian Joint Consortium for School Health to facilitate a comprehensive and coordinated approach to health promotion in the school setting. The JCSH received a second five-year mandate from the federal, provincial, and territorial deputy ministers of Health on June 19, 2009 and from the provincial and territorial deputy ministers of Education on September 03, 2009.

AND WHEREAS by virtue of this agreement ("the Agreement") being entered into by provincial and territorial Ministers of Education and the provincial and territorial Ministers of Health and/or Wellness, hereinafter collectively called "the Parties", the Pan-Canadian Joint Consortium for School Health ("JCSH") is continued (2015-2020).

THE PARTIES AGREE that the terms and conditions of their relationship are as follows:

1.0 Purpose of the Consortium

1.1 The purpose of the JCSH is to be a catalyst to strengthen cooperation and capacity among the Parties to better accomplish mutual goals and support shared mandates regarding the promotion of the health of children and youth in Canadian schools.

1.2 Recognizing that every province and territory has initiatives in place to foster healthy school environments, the JCSH provides a forum for key representatives of government ministries responsible for health and education to:

- strengthen cooperation among ministries, agencies, departments, and others in the support of healthy schools;
- build the capacity of the education and health sectors to work together more effectively and efficiently; and
- promote understanding of, and support for, the concept and benefits of comprehensive school health.

1.3 Three long-term outcomes associated with achieving the JCSH's Vision are:

- Increased System Capacity, Collaboration, and Efficiency
- Increased Research Coordination
- Increased Inter-Sectoral Action between Education and Health.

2.0 Commencement and Duration of Agreement

2.1 This Agreement commences April 1, 2015 and remains in force until March 31, 2020.

3.0 Governance Structure

Consortium Lead

3.1 British Columbia was the lead jurisdiction and hosted the JCSH Secretariat for

the first five years (2005-2010). Prince Edward Island served as the lead jurisdiction and Secretariat host for the second five-year mandate (2010-2015). The Parties agree that Prince Edward Island will be the lead jurisdiction and Secretariat host for the duration of this Agreement.

Advisory Committee of Deputy Ministers of Education and Conference of Deputy Ministers of Health

3.2 The JCSH will be governed by the Advisory Committee of Deputy Ministers of Education (ACDME) and the Conference of Deputy Ministers of Health (CDMH).

3.3 The CDMH shall invite the Public Health Agency of Canada to appoint a similarly senior representative to participate in discussions related to the JCSH in an advisory capacity.

3.4 The deputy minister of Health and the deputy minister of Education in the lead jurisdiction will act as liaisons between the JCSH and their respective provincial/territorial deputy ministers' tables. These liaison deputy ministers in the lead jurisdiction may name another deputy minister within the same sector in another jurisdiction to provide the leadership function.

3.5 As the governing bodies, the ACDME and the CDMH will provide strategic direction for the JCSH by:

- establishing a Management Committee as the operational committee of the JCSH;
- providing strategic information and direction to the Management Committee;
- approving the five-year strategic plan, submitted by the Management Committee to the ACDME and the CDMH;
- reviewing and accepting the annual report with financial statements, submitted by the Management Committee; and
- tabling the annual report at an annual intergovernmental meeting of the Ministers of Health and an annual intergovernmental meeting of the Ministers of Education.

3.6 Decisions of the ACDME and the CDMH shall be communicated by the respective liaison deputy ministers to the chair of the Management Committee.

4.0 JCSH Committees

Management Committee

4.1 The Management Committee provides the main forum for executive-level discussion and decisions affecting the work of the JCSH. Its members are appointed by the deputy ministers in each member jurisdiction and are generally positioned at the executive management level from the Health and/or Education department/ministry.

4.2 The Management Committee is chaired by a Management Committee member from the lead jurisdiction.

4.3 The roles and responsibilities of the Management Committee are outlined in the Management Committee Terms of Reference, attached as Schedule 2.

School Health Coordinators' Committee

4.4 The School Health Coordinators' Committee (SHCC) works collaboratively to move forward the work of the JCSH and its member provinces and territories through

the early identification and analysis of issues, gaps, emerging trends, and areas of interest.

4.5 School Health Coordinators' Committee members are appointed by each JCSH member jurisdiction.

4.6 The SHCC is co-chaired by a school health coordinator from the lead jurisdiction and a school health coordinator from another member jurisdiction. The co-chairs provide updates on the work of the SHCC to the Management Committee.

4.7 The SHCC is accountable to the Management Committee. Individual school health coordinators are accountable to their respective jurisdictions in the manner determined by individual jurisdictions.

4.8 The roles and responsibilities of the SHCC are outlined in the SHCC Terms of Reference, which are approved by the Management Committee.

5.0 JCSH Secretariat

5.1 The Parties agree to continue the operation of a JCSH Secretariat ("the Secretariat").

5.2 The Secretariat coordinates the activities of the JCSH, and provides administrative, policy, planning, logistical, and communication support to the JCSH and its members under the direction of the executive director.

5.3 The Secretariat is the central point of contact for JCSH members and maintains an active communication with other related organizations.

5.4 In collaboration with the JCSH member provinces and territories, the Secretariat promotes the collective voice and the collective impact of JCSH outcomes at meetings, conferences, and consultations across the country.

5.5 The lead jurisdiction hosts the JCSH Secretariat and is responsible for hiring, supervising, and evaluating the Secretariat executive director.

5.6 The executive director is responsible for hiring, supervising, and evaluating the Secretariat staff.

5.7 The executive director, following the financial policies of the lead jurisdiction, manages the budget of the JCSH.

6.0 Addition of a Provincial/Territorial Jurisdiction to the JCSH

6.1 A government entity may be invited to join the JCSH on the condition that it becomes a party to this Agreement. Participation is contingent upon payment of the amount in accordance with the formula as set out in the Cost-Sharing Agreement⁷.

7.0 Withdrawal of a Provincial/Territorial Jurisdiction from the JCSH

7.1 Any party can withdraw from the Agreement by providing 90-day written notification to the liaison deputy ministers in the lead jurisdiction.

⁷See Schedule 1.

7.2 In the event of withdrawal, the party shall pay a pro-rated portion of its

contribution fees for the fiscal year in which it withdraws from the JCSH.

8.0 Funding

8.1 The Parties agree to fund the salary, benefits, travel, and program costs associated with the obligations of their respective representatives serving on the Management Committee.

8.2 The Parties agree to fund the salary, benefits and program costs associated with the obligations of SHCC members. Travel costs associated with committee meetings for one school health coordinator member per jurisdiction will be covered by the JCSH. Travel costs associated with attendance at the Management Committee meetings will be covered by the JCSH for one SHCC co-chair.

8.3 The Parties agree to provide funding according to Schedule 1 of this Agreement. Funding obligations by parties are contingent each year upon federal government funding being provided for that year as specified in Schedule 1. The lead jurisdiction will invoice for member contribution fees by April 15th of each year of this Agreement; fees are due within thirty days of receipt of invoice, and are to be accounted for separately by the lead jurisdiction.

8.4 Notwithstanding any other provision of this Agreement, the payment of money by any Party is subject to:

(a) there being sufficient monies available in an appropriation, as defined in the applicable legislation of the jurisdiction of the relevant Party (the "Appropriation Legislation"), to enable the applicable Party, in any fiscal year or part thereof when any payment of money falls due under this Agreement, to make that payment; and

(b) the treasury board or other similar decision body of the applicable party, not having controlled or limited, under the Appropriation Legislation, expenditure under any appropriation referred to in paragraph (a).

8.5 The JCSH may seek other funding sources to supplement funding arrangements articulated in this Agreement.

9.0 General Provisions

Schedules

9.1 The Schedules shall have the same force and effect as if expressly set in the body of this Agreement and any reference to this Agreement shall include the Schedules.

Variation of the Agreement

9.2 This Agreement may be amended at any time by agreement of the Parties.

Termination of the Agreement by Mutual Agreement

9.3 This Agreement may be terminated at any time by unanimous agreement of the Parties.

9.4 Termination of this Agreement is without prejudice to the rights, duties and liabilities of the Parties accumulated prior to termination.

9.5 Intellectual property developed under the Agreement shall become the property of the Lead Jurisdiction at the time of termination. The Lead Jurisdiction shall grant licences to the Parties for full use of intellectual property developed pursuant to this agreement.

Legal Rights and Responsibilities

9.6 The creation of the Consortium does not constitute a regulatory power or otherwise result in any diminution of the responsibilities of the provincial or territorial

Ministers of Education, or any of the provincial or territorial Ministers of Health (or equivalent health promotion ministry).

9.7 The Agreement creates legal rights and responsibilities of the Parties with respect to Sections 2 (duration), 6 (withdrawal) and 7 (funding).

Evaluation

9.8 The Parties agree to further evaluation of the JCSH, as determined by the Management Committee.

Schedule 1: Cost-Sharing Agreement

Funding for the JCSH operations and the cost of the Secretariat will be shared among the federal and the provincial/ territorial jurisdictions:

- Public Health Agency of Canada will contribute \$250,000 annually; and
- Provinces and territories will match this contribution annually according to the schedule outlined below.

Funds are committed for five years commencing April 1, 2015.

Provincial/territorial jurisdictional contributions are based on a fixed contribution of \$2,000 annually plus a variable portion based on total population of their respective jurisdictions. Jurisdictions with less than one percent of the population will contribute the fixed portion only.

Proportional breakdown of the provincial/territory contribution:

Province / Territory	Total Population	Pop. %	Fixed	Variable	Total Contribution
AB	4,145,992	15%	\$2,000	\$34,294	\$36,394
BC	4,657,947	17%	\$2,000	\$38,529	\$40,529
MB	1,268,323	5%	\$2,000	\$10,640	\$12,640
NB	754,643	3%	\$2,000	\$6,242	\$8,242
NL	526,837	2%	\$2,000	\$4,358	\$6,358
NT	43,795	0%	\$2,000	\$0	\$2,000
NS	943,932	3%	\$2,000	\$7,808	\$9,808
NU	35,687	0%	\$2,000	\$0	\$2,000
ON	13,730,187	50%	\$2,000	\$113,571	\$115,571
PE	146,524	1%	\$2,000	\$1,212	\$3,212
SK	1,129,899	4%	\$2,000	\$9,326	\$11,346
YK	36,758	0%	\$2,000	\$0	\$2,000
Federal					\$250,000
Totals	27,459,524	100%	\$ 24,000	\$ 226,000	\$ 500,000

Appendix B: Pan-Canadian Joint Consortium for School Health Statement of Revenue, Expenses and Operating Surplus

For The Year Ended March 31, 2015

Revenue	2015		2014
Membership Fees	\$250,000		\$250,000
Public Health Agency of Canada	\$250,000		\$250,000
Other Revenue	\$1,729		\$1,538
Total	\$501,729		\$501,538
Expenses			
Knowledge Development and Exchange	\$17,242		\$45,368
Leadership	\$49,266		\$52,713
Capacity Building	\$79,908		\$173,890
Operations	\$328,050		\$335,470
Total	\$474,466		\$607,441
Operating Surplus/(Deficit)	\$27,263		(\$105,903)
Prior Year Operating Surplus/(Deficit)	\$170,487		\$276,390
Total Operating Surplus/(Deficit)	\$197,750		\$170,487

- The accumulated surplus is a result of reduced expenses in project initiatives during the period of planning for the JCSh mandate renewal for 2015-2020.

Appendix C: Member and Supporting Jurisdiction Contact Information and Web Links

British Columbia

School Health Coordinators:

Sanja Ristic

Senior Policy Analyst
Safe and Healthy Schools
Ministry of Education
PO Box 9183 Stn Prov Govt
Victoria, BC V8W 9H1
Tel: 250-893-6954
Fax: 250-356-8334
sanja.ristic@gov.bc.ca

Scott Beddall

School and Community Health Manager
Ministry of Health
PO Box 9646 Stn Prov Govt
Victoria, BC V8W 9P1
Tel: 250-952-2323
Fax: 250 952-1570
Scott.Beddall@gov.bc.ca

School Health Links:

www.healthyschoolsnetwork.org
www.healthyschools.bc.ca
www2.gov.bc.ca/gov/content/education-training/administration/kindergarten-to-grade-12/school-health
www.healthyfamiliesbc.ca/your-community/health-and-learning

Alberta

School Health Coordinator:

Gail Diachuk

School Health and Wellness Manager
Joint Position
Alberta Education/Alberta Health
8th Fl., 44 Capital Boulevard
10044-108 Street NW
Edmonton, AB T5J SE6
Tel: 780-644-5274
Fax: 780-422-9735
gail.diachuk@gov.ab.ca

School Health Links:

www.healthyalberta.com/HealthyPlaces/282.htm
www.education.alberta.ca/teachers/program/health.aspx

Saskatchewan

School Health Coordinators:

Jillian Code

Program & Policy Consultant
Health Promotion, Primary Health
Services Branch
Saskatchewan Ministry of Education
3475 Albert Street

Regina, SK S4S 6X6
Tel: 306-787-5930
jillian.code@health.gov.sk.ca

Jocelyn MacLeod

Consultant, Comprehensive
School Community Health
Programs Branch
Ministry of Education
2220 College Avenue
Regina, SK S4P 4V9
Tel: 306-787-1999
Fax: 306-787-2223
jocelyn.macleod@gov.sk.ca

Malinda Strueby

Consultant, Comprehensive
School Community Health Programs
Branch, Ministry of Education
2220 College Avenue
Regina, SK S4P 4V9
Tel: 306-787-1332
Fax: 306-787-2223
Malinda.strueby@gov.sk.ca

School Health Links :

<http://www.saskatchewan.ca/government/education-and-child-care-facility-administration/services-for-school-administrators/student-wellness-and-wellbeing>
(Comprehensive School Community Health, Caring and Respectful Schools, Anti-Bullying, Digital Fluency, Healthy Foods for School)
<http://www.saskatchewan.ca/residents/education-and-learning/first-nations-and-metis-education>
(Improving education outcomes for First Nations and Métis Students)
<http://www.saskatchewan.ca/government/education-and-child-care-facility-administration>
(Saskatchewan School Curriculum Link – English and French)
<http://www.saskatchewan.ca/residents/education-and-learning/anti-bullying>
(Anti-Bullying)
<http://www.saskatchewan.ca/residents/health>
(Health and Healthy Living)

Manitoba

School Health Coordinators:

Kaley Maksymyk

Healthy Schools Consultant
Manitoba Health, Healthy Living

and Seniors

4089 – 300 Carlton Street
Winnipeg MB R3B 3M9
Tel: 204-788-6394
Fax: 204-948-4748
Kaley.Maksymyk@gov.mb.ca

Paul Paquin

Curriculum Consultant
Physical and Health Education
Manitoba Education and Advanced Learning
1181 Portage Avenue, Suite 509
Winnipeg, MB R3G 0T3
Tel: 204-945-3529
Fax: 204-945-1625
Paul.Paquin@gov.mb.ca

School Health Links:

www.gov.mb.ca/healthyschools
www.gov.mb.ca/healthyschools/index.fr.html
www.manitobainmotion.ca/schools
www.edu.gov.mb.ca/k12/cur/physlth/index.html (English)
www.edu.gov.mb.ca/m12/progetu/epes/index.html (French)
www.edu.gov.mb.ca/k12/esd/ (English)
www.edu.gov.mb.ca/m12/dev/durable/index.html (French)

Ontario

School Health Coordinator:

Jennifer Munro-Galloway

Senior Policy Advisor
Healthy Schools Unit
Safe Schools and Student Well-Being Branch
Ministry of Education
Tel: 416-325-2678
Jennifer.Munro-Galloway@ontario.ca

School Health Links:

www.ontario.ca/healthyschools
(English)
<http://www.edu.gov.on.ca/fre/parents/healthyschools.html>
(French)
www.edu.gov.on.ca/eng/curriculum/elementary/health.html (English)
<http://www.edu.gov.on.ca/fre/curriculum/elementary/health.html> (French)
www.edu.gov.on.ca/eng/curriculum/secondary/health.html (English)

<http://www.edu.gov.on.ca/fre/curriculum/secondary/health.html>
(French)

<http://www.health.gov.on.ca/en/public/programs/concussions/>
(English)

<http://www.health.gov.on.ca/fre/public/programs/concussions/default.aspx> (French)

New Brunswick

School Health Coordinator:

Marlien McKay

Director, Wellness
Department of Social Development
Sartain MacDonald Building
551 King Street
P. O. Box 6000
Fredericton, NB E3B 5H1
Tel: 506-444-4633
Tel: 506-453-2280
Fax: 506-444-5722
marlien.mckay@gnb.ca

School Health Links:

http://www2.gnb.ca/content/gnb/en/departments/social_development/wellness/content/school.html

Nova Scotia

School Health Coordinators:

Sharon Young

Coordinator, Health Enhancement
Department of Health and Wellness
PO Box 488
1894 Barrington Street
Halifax, NS B3J 2R8
Tel: 902-424-2046
sharon.young@gov.ns.ca

Helen Pitman

Coordinator, Health Enhancement
Department of Health and Wellness
PO Box 488
1894 Barrington Street
Halifax, NS B3J 2R8
Tel: 902-424-2753
Fax: 902-424-3135
helen.pitman@gov.ns.ca

School Health Links:

<http://nshps.ca/>

Prince Edward Island

School Health Coordinator:

Sterling Carruthers

Healthy Schools Specialist
Department of Education, Early Learning
and Culture
250 Water Street, Suite 101
Summerside, PE C1N 1B6

Tel: 902-438-4134
Fax: 902-438-4062
sdccarruthers@edu.pe.ca

School Health Links:

<http://www.gov.pe.ca/healthyschoolcommunities/>

Newfoundland and Labrador

School Health Coordinators:

Carol Ann Cotter

Health Promotion Consultant
Healthy Living Division
Department of Seniors, Wellness and
Social Development
PO Box 8700
St. John's, NL A1B 4J6
Tel: 709-729-3939
Fax: 709-729-5824
carolanncotter@gov.nl.ca

Ellen Coady

Program Development Specialist for
Health, Family Studies, Home Economics
and Physical Education
Department of Education and
Early Childhood Development
PO Box 8700
St. John's, NL A1B 4J6
Tel: 709-729-6051
Fax: 709-729-1400
ellencoady@gov.nl.ca

School Health Links:

www.gohealthy.ca
www.livinghealthyschools.com

Nunavut

School Health Coordinators:

Charlotte Borg

Manager, Student Support Services
Department of Education
Government of Nunavut
PO Box 1000, Station 960
Iqaluit, NU X0A 0H0
Tel: 867-975-5679
Fax: 867-979-7924
cborg@gov.nu.ca

Sue Peterkova

Health Promotion Specialist
Department of Health
Government of Nunavut
PO Box 1000, Station 1000
Iqaluit, NU X0A 0H0
Tel: 867-975-5779
speterkova@gov.nu.ca

School Health Links:

www.gov.nu.ca/education/eng/css/progstudies7_12.htm

Northwest Territories

School Health Coordinator:

Elaine Stewart

Coordinator, Instructional and
School Services
and School Services
Department of Education, Culture
and Employment
Government of the Northwest Territories
PO Box 1320
Yellowknife, NT X1A 2L9
Tel: 867-873-7676
Fax: 867-873-0109

elaine_stewart@gov.nt.ca

Elaine.Stewart@learnnet.nt.ca

School Health Links :

www.ece.gov.nt.ca/Divisions/kindergarten_g12/indexk12.htm

Yukon

School Health Coordinators:

Anne Aram

A/Manager, Health Promotion Unit
Department of Health and Social Services
305 Jarvis St., 2nd Floor
Whitehorse, YT Y1A 2H3
Tel: 867-456-6576
Fax: 867-456-6502
Anne.Aram@gov.yk.ca

Stacey Burnard

Social Emotional Educational Psychologist
Department of Education
1000 Lewes Boulevard
Whitehorse, YT Y1A 2C6
Tel: 867-334-7636
Fax: 867-393-6423
Stacey.burnard@gov.yk.ca

School Health Links:

www.hss.gov.yk.ca/programs/health_promotion/

Public Health Agency of Canada

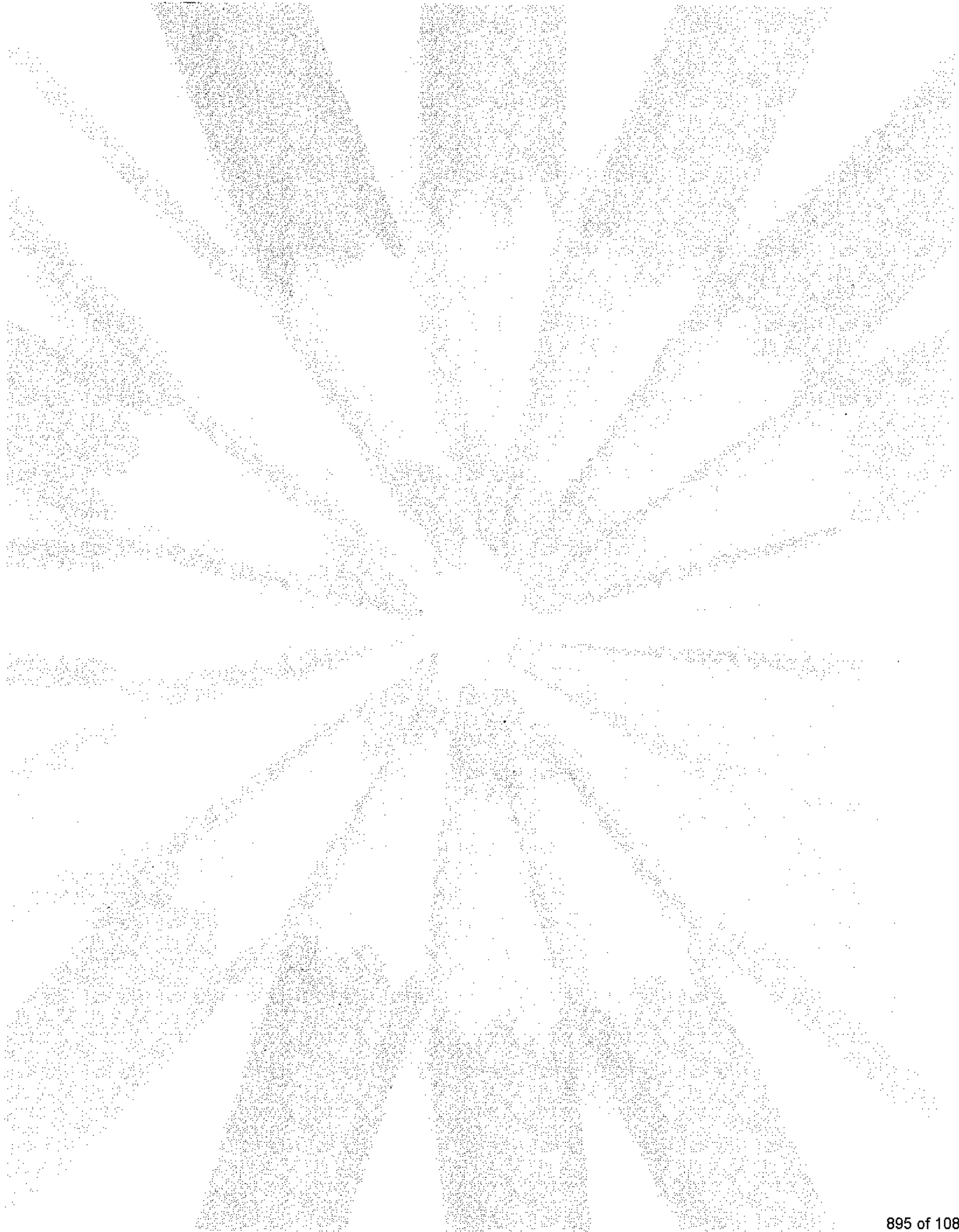
Louise Aubrey

Senior Policy Analyst
Youth Policy Unit
Division of Children, Seniors and Healthy
Development
Centre for Health Promotion
Health Promotion and Chronic Disease
Prevention Branch
Public Health Agency of Canada
785 Carling Avenue, AL 6B04B
Ottawa, ON K1A 0K9
Tel: 613-852-2007
Fax: 613-960-6987

Louise.Aubrey@phac-aspc.gc.ca

PHAC's website:

<http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/school-health/>





Pan-Canadian
Joint Consortium for School Health
Governments Working Across the Health and Education Sectors

Pan-Canadian Joint Consortium for School Health
Holman Centre , Suite 101
250 Water Street
Summerside PE C1N 1B6
Tel: 902-438-4895
Fax: 902-438-4889
www.jcsh-cces.ca
inquiry@jcsh-cces.ca

Scheffel, Emile HLTH:EX

From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 6:29 PM
To: Scheffel, Emile HLTH:EX
Cc: Marr, Ann HLTH:EX
Subject: RE: Health Ministers' Meeting Materials
Attachments: FPT HMM eBinder_draft Jan 12.pdf

Hi Emile,

Please see attached a draft FPT HMM e-binder. Please note – we are still reviewing the content provided today by Health Canada and so may have some adjustments to the BC Program Notes included in the e-binder. However, we wanted to make sure you had a draft as early as possible.

Thanks,
Tricia

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 5:04 PM
To: Poilievre, Tricia HLTH:EX
Cc: Marr, Ann HLTH:EX
Subject: RE: Health Ministers' Meeting Materials

Great, thanks!

From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 5:03 PM
To: Scheffel, Emile HLTH:EX
Cc: Marr, Ann HLTH:EX
Subject: Health Ministers' Meeting Materials

Hi Emile,

Please find attached the following materials for the Minister in preparation for the Thursday briefing:

- At a Glance Agenda
- Conference Information e-binder (this includes the itinerary)
- Jan 20 – PT HMM e-binder

Health Canada has just sent out the full package of briefing documents, so we will send a binder for the FPT day early tomorrow. We have requested materials on the separate meetings the Minister is attending (CFNU, CMA, e-cigarettes) and will add those to the e-binders as soon as they are received.

For the e-binders, he can navigate through the documents using bookmarks. We're also happy to pull out individual documents separately, if he prefers. If you have any questions, please let me know.

Thanks!

Tricia Poilievre
A/Director | Intergovernmental Relations | Ministry of Health, BC
Office: 250 952-1304 | Cell: 250 415-2639 | tricia.poilievre@gov.bc.ca

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 1045663

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

TITLE: Launch of Carrot Rewards

PURPOSE: To support a public launch of the Carrot Rewards national healthy living platform.

BACKGROUND:

The Ministry of Health (the Ministry), in partnership with the Public Health Agency of Canada (PHAC) and Social Change Rewards (SCR), is preparing to support the official launch of the innovative healthy living platform called Carrot Rewards. The partners are poised to have all elements in place to enable a public launch of Carrot Rewards in early 2016. The preferred approach is to have the Minister of Health participate in a public event or announcement of the release of Carrot Rewards, pending his interest and availability for the proposed timeframe.

Carrot Rewards will be available exclusively to British Columbians for a period of three months from date of launch. Confirmed points providers for the launch include SCENE, Aeroplan, Overwaitea, and Petro Points. SCR continues to negotiate with other potential point providers and the roster for that will continue to be of interest to the Ministry as the app grows in usage.

The Ministry, PHAC and SCR are working together to ensure that all elements are in place for a secure and successful launch. A central component of marketing Carrot Rewards will be through the opt-in databases that the point providers have, connecting to upwards of 850,000 British Columbian email addresses. The email promotion from each point provider will offer an incentive from their loyalty program for downloading the app. That email will also recognize the government partners and the national NGO partners (YMCA Canada, Heart & Stroke Foundation and the Canadian Diabetes Association). Extensive forecast modeling is in place to monitor engagement of this first invitation to British Columbians.

In preparation for the launch, SCR has hired a third-party privacy consultant to review privacy practices. This builds off the guidance provided by the Ministry's Health Information Privacy, Security and Legislation Branch which has concluded a Privacy Impact Assessment (PIA), signed off by the Office of the Information and Privacy Commissioner of BC.. A final revision of the privacy statement and supporting policy will be submitted with the PIA to the respective governments and the BC Healthy Living Alliance, in its role to support the Ministry's interests on this project.

SCR is responsible for providing technical support and will soft-launch to test technical issues prior to an announcement. An app demo will be made available to share with the Minister in advance of the announcement. The evaluation framework is being finalized and is led by PHAC and SCR, with the Ministry and the BC Healthy Living Alliance (BCHLA) participating in the process. Dr. Guy Faulkner, who holds a research chair position with UBC in Applied Public Health, will provide an impartial evaluation to the framework. Evaluation of the project includes short, medium and long term measures,

based on behavioural insights theory. SCR will be providing ongoing reporting to the BCHLA and the Ministry of the performance to guide the roll-out of content and demonstrate in-app activity and associated metrics.

Carrot Rewards is the result of a collaborative effort between PHAC, the Ministry (through partnership funding to the BCHLA) and Social Change Rewards along with its national, Non-Government Organizations (NGO) partners (YMCA Canada, Heart & Stroke Foundation and Canadian Diabetes Association). Having the BC Healthy Living Alliance on board complements the national NGO supporters and ensures we are addressing shared priorities toward reducing chronic disease and improved health outcomes.

DISCUSSION:

s.13

OPTIONS:

1. Support a proposed joint event with PHAC, the Ministry, BCHLA, SCR and NGO partners at the end of January 2016, to generate media and engagement opportunities.

s.13

FINANCIAL IMPLICATIONS:

Carrot Rewards is cost-shared by a \$5 million contribution from PHAC to Social Change Rewards and a \$2.5 million contribution by the Ministry, through a partnership with the BC Healthy Living Alliance. The program will reach a potential overall investment of \$12.5 million through in-kind contributions of up to \$5 million by Social Change Rewards. The investment from all parties is over a period of up to five years and is based on a pay-for-performance model.

RECOMMENDATION:

Option 1: Support the launch of Carrot Rewards and consider an opportunity for a joint event in late January 2016.



Approved/Not Approved
Terry Lake
Minister

Jan.11, 2016

Date Signed

Program ADM/Division: Population Health Surveillance and Public Health Planning, PPH

Telephone: 250-952-1467

Program Contact (for content): Regan Hansen, Director Health Engagement Unit

Drafter: Ashley Walden, Senior Manager Health Engagement Unit

Date: updated December 31, 2016

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:30 PM
To: Scheffel, Emile HLTH:EX
Subject: 1045663 - Launch of Carrot Rewards - DBN.pdf
Attachments: 1045663 - Launch of Carrot Rewards - DBN.pdf; ATT00001.txt

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 1042318

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

TITLE: Nursing Regulations

PURPOSE: To amend the nursing regulations which include the Nurses (Registered) and Nurse Practitioner Regulation, the Nurses (Registered Psychiatric) Regulation, the Nurses (Licensed Practical) Regulation, in accordance with the *Health Professions Act* (HPA) and the Prescribed Health Care Professions Regulation in accordance with the *Pharmacy Operations and Drug Scheduling Act*.

BACKGROUND:

BC has implemented the shared scope of practice/restricted activities regulatory model for self-regulating health professions. Nursing regulations required amendments in order to fully transition under the model and provide clarity regarding the scope of practice and restricted activities of the various types of nursing professions.

After receiving Minister approval, the proposed amendments were posted on the Ministry of Health (the Ministry) and college websites for a 90-day consultation period from April 9, 2015 to July 9, 2015. s.13

s.13

During the consultation period, a variety of stakeholders offered input including the three nursing regulatory colleges, the Chief Nursing Officer Council (CNO), the BC Coalition of Nursing Associations, BC Nurses Union (BCNU) as well as from a number of individuals. The CNO includes representatives of each of the health authorities, and the BC Coalition of Nursing Associations represented all of the nursing associations. s.13

DISCUSSION:

The feedback from the consultation period falls into three categories.

1. Comments indicating administrative errors, unintentional omissions and recommendations for accurately reflecting current scopes of practice. These comments have been addressed in the final version of the regulations. It is unlikely that these changes will cause concern amongst stakeholders. Examples include:
 - adding the definition of 'issue' from the RN regulation to both the RPN and LPN regulation for consistency and clarity;
 - removal of "for the purpose of oral pharyngeal suctioning" from the description of a restricted activity as this is anatomically inaccurate;

- re-inserting the ability for LPNs to deliver services for immunization programs without an order. This was originally included, but inadvertently deleted;
- enabling RPNs to administer authorized drugs by any method, including intravenously. "Intravenously" was excluded in the previous draft, but its addition reflects current practice.

s.13

3. Comments that do not affect the language of the regulation, but may be relevant to implementation by employers or regulators. These comments will be shared with the CNOs and nursing colleges.

Enclosed:

Appendix A – Includes the Nurses (Registered) and Nurse Practitioner Regulation Ministerial Order, yellow tag, schedule, redline and regulation criteria checklist.

Appendix B – Includes the Nurses (Registered Psychiatric) Regulation Ministerial Order, yellow tag, schedule, redline and regulation criteria checklist.

Appendix C – Includes the Nurses (Licensed Practical) Regulation Ministerial Order, yellow tag, schedule, redline and regulation criteria checklist.

Appendix D – Includes the Prescribed Health Care Professions Regulation Ministerial Order, green tag, redline and regulation criteria checklist.

FINANCIAL IMPLICATIONS: N/A

IMPACT ON REGULATORY COUNT: NONE

RECOMMENDATION: The Minister signs this Order as drafted.



Approved/Not Approved
Honourable Terry Lake, Minister of Health
Minister of Health

Jan 11, 2016
Date Signed

Program ADM/Division: Ted Patterson, ADM, Health Sector Workforce Division

Telephone: 250-952-3465

Program Contact (for content): Brian Westgate, Professional Regulation and Oversight

Drafter: Ranique Sekhon, Senior Policy Analyst, Professional Regulation and Oversight

Date: December 23, 2015

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:33 PM
To: Scheffel, Emile HLTH:EX
Subject: 1042318 - Nursing Regulations.pdf
Attachments: 1042318 - Nursing Regulations.pdf; ATT00001.txt

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 10:33 PM
To: Hughes, Doug J HLTH:EX; Brown, Stephen R HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Re: 1038930 - Increasing Quality and Capacity for Care - FHA Plan.pdf

Thanks Doug.

Sent from my BlackBerry 10 smartphone on the TELUS network.

Original Message

From: Hughes, Doug J HLTH:EX
Sent: Tuesday, January 12, 2016 7:47 PM
To: Lake, Terry HLTH:EX; Brown, Stephen R HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Re: 1038930 - Increasing Quality and Capacity for Care - FHA Plan.pdf

Good evening Minister. Michael Marchbank had discussions with BCNU over the summer on this plan and I am told has agreement on this plan. If you want more info I can check back with Michael tomorrow.

Sent from my BlackBerry 10 smartphone on the TELUS network.

Original Message

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:48 PM
To: Brown, Stephen R HLTH:EX; Hughes, Doug J HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: 1038930 - Increasing Quality and Capacity for Care - FHA Plan.pdf

Steve and Doug

Can we make certain the FHA brings nurses into the discussion early when contemplating nursing models of care changes?

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

From: Scott.Ryckman@gov.bc.ca
Sent: Tuesday, January 12, 2016 9:33 PM
Subject: TNO Media Overview
Attachments: overview_20160112.pdf

Daily Today's News Online Media Overview
Tuesday, January 12, 2016

CHAN - Global BC Early News with Robin Stickley 17:00 hr		
Placement	Time	Story
Intro		Value of Canadian dollar continues to fall - nation's economic slowdown will continue Metro Vancouver considering unusual safety improvement along Barnet Highway
Top Story	1700	BC's tourism & movie industries benefiting from weaker Canadian dollar
2/6	1703	BCers buying lottery tickets in US warned to be aware of arcane American law
3/6	1704	Former Surrey soccer coach pleads guilty to sex-related charges in United States
4/6	1704	Burnaby seeks public input on proposed development near Gilmore SkyTrain Station
5/6	1705	Port Moody council set to vote on plan to add texture along stretch of Barnet Highway
6/6	1706	Traffic report
	1707	First commercial break

CHAN - Global BC News Hour with Chris Gailus 18:00 hr		
Placement	Time	Story
Intro		Home buyers given chance to buy a Metro Vancouver condo without a down payment Arcane law could prevent British Columbians from claiming lottery jackpots in US Metro Vancouver considering unusual safety improvement along Barnet Highway
Top Story	1800	Home buyers given a chance to buy a Port Moody condo without a down payment
2/14	1803	Burnaby seeks public input on proposed development near Gilmore SkyTrain Station
3/14	1806	Value of Canadian dollar continues to fall - having a mixed impact on nation's economy
4/14	1809	BCers buying lottery tickets in US warned to be aware of arcane American law
5/14	1812	Weather report
6/14	1813	German announcers describe crucial play during recent Seattle-Minnesota NFL game
	1814	First commercial break
7/14	1815	Former Surrey soccer coach pleads guilty to sex-related charges in United States
8/14	1816	Court ruling adds to confusion regarding medicinal marijuana dispensaries in BC
9/14	1818	BC government announces \$3m in funding for groundbreaking cancer research project
10/14	1819	Upcoming BC budget may provide relief from high MSP premiums & housing costs
11/14	1821	Traffic report
	1822	Second commercial break
12/14	1824	Port Moody council set to vote on plan to add texture along stretch of Barnet Highway
13/14	1827	Weather report
14/14	1829	New Jersey co-workers mistakenly believe they win Powerball jackpot
	1830	Third commercial break

CHEK - CHEK News at Five with Stacy Ross 1700 hr		
Placement	Time	Story
Intro		BC Ferries loses millions of dollars after selling Queen of Chilliwack to a former worker New transitional shelter on Vancouver Island offering hope to homeless people Value of beleaguered Canadian dollar continues to decline amid economic uncertainty
Top Story	1700	NDP critical of Queen of Chilliwack selling price - sold to former BC Ferries employee
2/7	1703	New transitional shelter in city of Victoria helping homeless people improve their lives
3/7	1705	Consumers across British Columbia feeling impact of weaker Canadian dollar
4/7	1708	Cowichan Valley bailiff helps victims of foreclosure find supportive housing
5/7	1710	Group of Langford residents preparing to help victims of 2010 earthquake in Haiti
6/7	1712	Organizers prepare for launch of winterJAM festival in Courtenay & Mount Washington
7/7	1715	Weather report
	1716	First commercial break

CIVT - CTV News at Five with Coleen Christie 1700 hr		
Placement	Time	Story
		Consumers in British Columbia expected to feel impact of weaker Canadian dollar

7/14	1706	Investigators trying to determine cause of explosion & fire at Port Moody sawmill
8/14	1706	Class action lawsuit launched against WorkSafeBC by employees of two BC sawmills
9/14	1706	Woman sent to hospital with serious injuries after train collides into car in Chilliwack
10/14	1707	Strata council in Langley trying to prevent condo owner from smoking in his home
11/14	1708	CTV Vancouver asks if tenants should be allowed to smoke in apartment buildings
12/14	1708	School district urged not to spread crumb rubber on sports fields in greater Victoria
13/14	1709	Coast Capital Savings Credit Union opens new headquarters in city of Surrey
14/14	1710	Weather report
	1710	First commercial break

CIVT - CTV News at Six with Mike Killeen & Tamara Taggart 1800 hr		
Placement	Time	Story
Intro		Consumers in British Columbia expected to feel impact of weaker Canadian dollar Metro Vancouver communities prepare for potential impact of anticipated king tide BCers buying lottery tickets in US warned to be aware of obscure American law
Top Story	1800	British Columbians expected to feel impact of weaker Canadian dollar at grocery stores
2/12	1802	Petroleum prices not expected to fall below a \$1/litre at Metro Vancouver gas stations
3/12	1803	Metro Vancouver cities enact flood prevention strategies ahead of anticipated king tide
4/12	1806	Assistant teacher identified as victim of party bus accident in downtown Vancouver
5/12	1807	Woman sent to hospital with serious injuries after train collides into car in Chilliwack
6/12	1807	Former Surrey soccer coach pleads guilty to sex-related charges in United States
7/12	1808	Diamond stolen by thieves during break & enter at Burnaby Neighbourhood House
8/12	1809	Investigators trying to determine cause of explosion & fire at Port Moody sawmill
9/12	1809	Class action lawsuit launched against WorkSafeBC by employees of two BC sawmills
10/12	1809	Federal cabinet ministers in Vancouver to gather input for national MMIW inquiry
11/12	1811	Strata council in Langley trying to prevent condo owner from smoking in his home
12/12	1812	Premier Clark announces \$3m in funding for groundbreaking cancer research project
	1814	First commercial break

CBUT - CBC News Vancouver with Andrew Chang 1800 hr		
Placement	Time	Story
Intro		Post-secondary school in British Columbia opens nap room for exhausted students Metro Vancouver now accepting discarded coffee pods in recycling bins
Top Story	1800	Americans waiting in long lineups to purchase Powerball lottery tickets
2/13	1801	British Columbians travelling to United States to purchase Powerball lottery tickets
3/13	1801	American entrepreneur reporting strong demand for Powerball lottery tickets
4/13	1803	Canadians would receive approximately \$800m if they win Powerball lottery jackpot
5/13	1804	Odds of winning America's Powerball lottery jackpot estimated at 1 in 292m
6/13	1805	Canadians discouraged from purchasing Powerball lottery tickets online
7/13	1806	Home buyers given a chance to buy a Port Moody condo without a down payment
8/13	1809	Premier Clark announces \$3m in funding for groundbreaking cancer research project
9/13	1813	Metro Vancouver now recycling discarded coffee pods - coffee grinds must be removed
10/13	1815	CBC outlines items that are permitted in Metro Vancouver recycling bins
11/13	1816	City of Vancouver website outlines items that are permitted in recycling bins
12/13	1817	Abbotsford police produce short film to teach young people about domestic violence
13/13	1819	Weather report
	1820	First commercial break

CIVI - CTV News Live @ 5 with Joe Perkins 1700 hr		
Placement	Time	Story
Intro		Weaker Canadian dollar having a mixed impact on Canadian economy Victoria mayor baffled by latest proposal in CRD sewage treatment project School district urged not to spread crumb rubber on sports fields in greater Victoria
Top Story	1700	BC's tourism & movie industries expected to benefit from weaker Canadian dollar
2/8	1704	Oak Bay major trying to resurrect rejected location for CRD sewage treatment plant
3/8	1706	Residents say crime has increased in area around tent city behind Victoria courthouse
4/8	1707	Security increased at middle school near temporary homeless shelter in Victoria
5/8	1708	Premier Clark says housing affordability will be addressed in upcoming BC budget
6/8	1709	SD61 urged not to spread crumb rubber on new sports field at Oak Bay High School
7/8	1710	ALC approves removal of 10 acres of farmland from ALR near Victoria airport
8/8	1712	Weather report
	1712	First commercial break

Story summaries appearing in blue feature a transcript. Summaries appearing in green feature a video. Click story summary to access.

Daily Today's News Online Media Overview
 Tuesday, January 12, 2016

CHAN - Global BC Early News with Robin Stickley 17:00 hr		
Placement	Time	Story
Intro		Value of Canadian dollar continues to fall - nation's economic slowdown will continue Metro Vancouver considering unusual safety improvement along Barnet Highway
Top Story	1700	BC's tourism & movie industries benefiting from weaker Canadian dollar
2/6	1703	BCers buying lottery tickets in US warned to be aware of arcane American law
3/6	1704	Former Surrey soccer coach pleads guilty to sex-related charges in United States
4/6	1704	Burnaby seeks public input on proposed development near Gilmore SkyTrain Station
5/6	1705	Port Moody council set to vote on plan to add texture along stretch of Barnet Highway
6/6	1706	Traffic report
	1707	First commercial break

CHAN - Global BC News Hour with Chris Gailus 18:00 hr		
Placement	Time	Story
Intro		Home buyers given chance to buy a Metro Vancouver condo without a down payment Arcane law could prevent British Columbians from claiming lottery jackpots in US Metro Vancouver considering unusual safety improvement along Barnet Highway
Top Story	1800	Home buyers given a chance to buy a Port Moody condo without a down payment
2/14	1803	Burnaby seeks public input on proposed development near Gilmore SkyTrain Station
3/14	1806	Value of Canadian dollar continues to fall - having a mixed impact on nation's economy
4/14	1809	BCers buying lottery tickets in US warned to be aware of arcane American law
5/14	1812	Weather report
6/14	1813	German announcers describe crucial play during recent Seattle-Minnesota NFL game
	1814	First commercial break
7/14	1815	Former Surrey soccer coach pleads guilty to sex-related charges in United States
8/14	1816	Court ruling adds to confusion regarding medicinal marijuana dispensaries in BC
9/14	1818	BC government announces \$3m in funding for groundbreaking cancer research project
10/14	1819	Upcoming BC budget may provide relief from high MSP premiums & housing costs
11/14	1821	Traffic report
	1822	Second commercial break
12/14	1824	Port Moody council set to vote on plan to add texture along stretch of Barnet Highway
13/14	1827	Weather report
14/14	1829	New Jersey co-workers mistakenly believe they win Powerball jackpot
	1830	Third commercial break

CHEK - CHEK News at Five with Stacy Ross 1700 hr		
Placement	Time	Story
Intro		BC Ferries loses millions of dollars after selling Queen of Chilliwack to a former worker New transitional shelter on Vancouver Island offering hope to homeless people Value of beleaguered Canadian dollar continues to decline amid economic uncertainty
Top Story	1700	NDP critical of Queen of Chilliwack selling price - sold to former BC Ferries employee
2/7	1703	New transitional shelter in city of Victoria helping homeless people improve their lives
3/7	1705	Consumers across British Columbia feeling impact of weaker Canadian dollar
4/7	1708	Cowichan Valley bailiff helps victims of foreclosure find supportive housing
5/7	1710	Group of Langford residents preparing to help victims of 2010 earthquake in Haiti
6/7	1712	Organizers prepare for launch of winterJAM festival in Courtenay & Mount Washington
7/7	1715	Weather report
	1716	First commercial break

CIVT - CTV News at Five with Coleen Christie 1700 hr		
Placement	Time	Story
Intro		Consumers in British Columbia expected to feel impact of weaker Canadian dollar Metro Vancouver communities prepare for potential impact of anticipated king tide BC government announces funding for groundbreaking cancer research
Top Story	1700	Former Surrey soccer coach pleads guilty to sex-related charges in United States
2/14	1701	British Columbians expected to feel impact of weaker Canadian dollar at grocery stores
3/14	1703	BC's tourism & movie industries benefiting from weaker Canadian dollar
4/14	1704	Petroleum prices not expected to fall below a \$1/litre at Metro Vancouver gas stations
5/14	1704	City of Vancouver officially rejects proposed Trans Mountain pipeline expansion project
6/14	1705	Alberta Premier dismisses call for her resignation from wealthy businessperson
7/14	1706	Investigators trying to determine cause of explosion & fire at Port Moody sawmill
8/14	1706	Class action lawsuit launched against WorkSafeBC by employees of two BC sawmills
9/14	1706	Woman sent to hospital with serious injuries after train collides into car in Chilliwack
10/14	1707	Strata council in Langley trying to prevent condo owner from smoking in his home
11/14	1708	CTV Vancouver asks if tenants should be allowed to smoke in apartment buildings
12/14	1708	School district urged not to spread crumb rubber on sports fields in greater Victoria
13/14	1709	Coast Capital Savings Credit Union opens new headquarters in city of Surrey
14/14	1710	Weather report
	1710	First commercial break

CIVT - CTV News at Six with Mike Killeen & Tamara Taggart 1800 hr		
Placement	Time	Story
Intro		Consumers in British Columbia expected to feel impact of weaker Canadian dollar Metro Vancouver communities prepare for potential impact of anticipated king tide BCers buying lottery tickets in US warned to be aware of obscure American law
Top Story	1800	British Columbians expected to feel impact of weaker Canadian dollar at grocery stores
2/12	1802	Petroleum prices not expected to fall below a \$1/litre at Metro Vancouver gas stations
3/12	1803	Metro Vancouver cities enact flood prevention strategies ahead of anticipated king tide
4/12	1806	Assistant teacher identified as victim of party bus accident in downtown Vancouver
5/12	1807	Woman sent to hospital with serious injuries after train collides into car in Chilliwack
6/12	1807	Former Surrey soccer coach pleads guilty to sex-related charges in United States
7/12	1808	Diamond stolen by thieves during break & enter at Burnaby Neighbourhood House
8/12	1809	Investigators trying to determine cause of explosion & fire at Port Moody sawmill
9/12	1809	Class action lawsuit launched against WorkSafeBC by employees of two BC sawmills
10/12	1809	Federal cabinet ministers in Vancouver to gather input for national MMIW inquiry
11/12	1811	Strata council in Langley trying to prevent condo owner from smoking in his home
12/12	1812	Premier Clark announces \$3m in funding for groundbreaking cancer research project
	1814	First commercial break

CBUT - CBC News Vancouver with Andrew Chang 1800 hr		
Placement	Time	Story
Intro		Post-secondary school in British Columbia opens nap room for exhausted students Metro Vancouver now accepting discarded coffee pods in recycling bins
Top Story	1800	Americans waiting in long lineups to purchase Powerball lottery tickets
2/13	1801	British Columbians travelling to United States to purchase Powerball lottery tickets
3/13	1801	American entrepreneur reporting strong demand for Powerball lottery tickets
4/13	1803	Canadians would receive approximately \$800m if they win Powerball lottery jackpot
5/13	1804	Odds of winning America's Powerball lottery jackpot estimated at 1 in 292m
6/13	1805	Canadians discouraged from purchasing Powerball lottery tickets online
7/13	1806	Home buyers given a chance to buy a Port Moody condo without a down payment
8/13	1809	Premier Clark announces \$3m in funding for groundbreaking cancer research project
9/13	1813	Metro Vancouver now recycling discarded coffee pods - coffee grinds must be removed
10/13	1815	CBC outlines items that are permitted in Metro Vancouver recycling bins
11/13	1816	City of Vancouver website outlines items that are permitted in recycling bins
12/13	1817	Abbotsford police produce short film to teach young people about domestic violence
13/13	1819	Weather report
	1820	First commercial break

CIVI - CTV News Live @ 5 with Joe Perkins 1700 hr		
Placement	Time	Story
Intro		Weaker Canadian dollar having a mixed impact on Canadian economy Victoria mayor baffled by latest proposal in CRD sewage treatment project School district urged not to spread crumb rubber on sports fields in greater Victoria
Top Story	1700	BC's tourism & movie industries expected to benefit from weaker Canadian dollar
2/8	1704	Oak Bay mayor trying to resurrect rejected location for CRD sewage treatment plant
3/8	1706	Residents say crime has increased in area around tent city behind Victoria courthouse
4/8	1707	Security increased at middle school near temporary homeless shelter in Victoria
5/8	1708	Premier Clark says housing affordability will be addressed in upcoming BC budget
6/8	1709	SD61 urged not to spread crumb rubber on new sports field at Oak Bay High School
7/8	1710	ALC approves removal of 10 acres of farmland from ALR near Victoria airport
8/8	1712	Weather report
	1712	First commercial break

Story summaries appearing in blue feature a transcript. Summaries appearing in green feature a video. Click story summary to access.
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Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 7:27 PM
To: Scheffel, Emile HLTH:EX
Subject: Re: New submission from Contact Your Constituency

Yep

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:24 PM
To: Robertson, Derek HLTH:EX
Subject: Re: New submission from Contact Your Constituency

Hey did this go to staff?

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 7:10 AM
To: Morris, Kirsty L LASS:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Re: New submission from Contact Your Constituency

Thanks Kirsty, and Good Morning :)

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

From: Morris, Kirsty L
Sent: Tuesday, January 12, 2016 7:08 AM
To: Robertson, Derek HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: Fwd: New submission from Contact Your Constituency

Hi Derek

Another one from the constit about the smoking cessation program - still having problems - she is now threatening going to the media on this.

Thanks Kirsty

To: "Morris, Kirsty L" <Kirsty.Morris@leg.bc.ca>
Subject: Re: New submission from Contact Your Constituency

Well another 60km trip to the pharmacy, and was told that
pharmacare would not cover the stop smoking aids as I have

s.22

s.22

I now think I should be billing BC
Medical for the 120 km that I have wasted since they can not get
their act together. I want something done about this ASAP. I
have no choice but to contact the media if I do not hear back
from MSP within 3 days. My home phone number is ^{s.22}
and Cell number is ^{s.22}.

s.22

On Mon, Jan 11, 2016 at 10:05 AM, Morris, Kirsty L <Kirsty.Morris@leg.bc.ca> wrote:

Dear ^{s.22}

Thank you for your email to MLA Terry Lake. I am sorry to hear that you experienced some difficulties
re accessing the new smoking cessation program. I have forwarded your email through to the Ministry
of Health for their response to your concerns.

Regards

Kirsty

Kirsty L Morris | Constituency Assistant

***Terry Lake, MLA Kamloops - North Thompson
Minister of Health***

Email: kirsty.morris@leg.bc.ca
Phone #: [250-554-5413](tel:250-554-5413) Fax #: [250-554-5417](tel:250-554-5417)
Toll Free #: [1-888-299-0805](tel:1-888-299-0805)
Website: www.terrylakemla.bc.ca



Be Green! Read from the screen

From s.22 [mailto:s.22]
Sent: January 7, 2016 12:17 AM
To: Lake.MLA, Terry <Terry.Lake.MLA@leg.bc.ca>
Subject: New submission from Contact Your Constituency

Name

s.22

Email

s.22

Riding

Kamloops – North Thompson

Comments & Feedback

Re: New Smoking Cessation Aid

I went to my pharmacy as was stated on the news, pharmacy was great and went right to work, filling out the paper work for both me and my husband, he got his no problem, but for myself pharmacare said that since

s.22 . It took me 3 phone calls, and 1 1/2 hrs on the phone to straighten it out. I have been paying MSP for 25 years and it took all that, in order for me to get the aid to quit smoking. If the government is going to cover the full cost as they are saying, why are they trying to have peoples extended health care, or other service providers pay for it. Either they cover it or they do not

s.22 it will now cost me another 60 km trip to get the aids. I can little afford this as
s.22 so I live on a very limited budget, gas is expensive due to living in a rural village, an especially since 7.5 cents per litre was added. Yes there is a bus here that will take us into town, but i can not sit around for 3 hrs. before you can catch one back. Due to distances we have no option but to! drive here, the same for many other rural communities, this needs to be addressed by your government, there should be a gasoline rebate. We in rural BC have no choice but to drive.

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 7:05 PM
To: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: Re: Quote Approval - Post-secondary students learn about a healthier drinking culture

Thanks Emile.

Sent from my BlackBerry 10 smartphone on the TELUS network.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:04 PM
To: Dhanowa, Damon HLTH:EX; Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: Re: Quote Approval - Post-secondary students learn about a healthier drinking culture

FYI Minister, GCPE is talking to AVED about a potential event.

Thanks E

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 10:34 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: Quote Approval - Post-secondary students learn about a healthier drinking culture

Good morning Minister – This NR is for release tomorrow afternoon after caucus releases go in the am. Thanks :Ds.17,s.22

“As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning,” said Lake. “Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person’s life can help set them on the right track.”

Post-secondary students learn about a healthier drinking culture

VICTORIA – Students at B.C. public post-secondary institutions will have access to additional supports to address substance use thanks to a \$400,000 investment for a project co-led by the Centre for Addictions Research of BC and the Canadian Mental Health Association BC Division, Health Minister Terry Lake announced today.

According to the 2013 National College Health Assessment Canadian survey, 26% of post-secondary students reported that the last time they socialized, they had seven or more drinks and 39% of students who drank alcohol in the last year said they later regretted something they did when drinking.

“As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning,” said Lake. “Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person’s life can help set them on the right track.”

Changing the Culture of Substance Use is a project currently being implemented at 11 public post-secondary institutions throughout British Columbia. Changing the culture of alcohol and substance use is a long-term process that requires engagement from several levels of society, including communities, organizations, campus administration and individuals.

"The Centre for Addictions Research of BC at the University of Victoria is pleased to continue its partnership with the Ministry of Health to ensure available evidence is utilized in real-world applications that improve the health of British Columbians," said Dan Reist, an assistant director at the centre. "In particular, the investment in changing the culture of substance use on post-secondary campuses currently supports locally-developed, centrally-supported projects at 11 institutions and active planning at several others."

Examples of existing resources include the Drink with Class campaign at Thompson Rivers University which targets students during their first six weeks in residence with multiple programs, policies and strategies to encourage responsible drinking. As well, Selkirk College has a Dinner Baskets program, designed to offer students the opportunity to prepare and enjoy a meal together on a regular basis, and to talk about substance use on campus and how the culture can be changed.

"As someone who is going on their fourth year living in this residence, I have noticed a big change in how people drink and party in residence," said Hailee-Jean Lindgren, a student at Thompson Rivers University in Kamloops. "In my first year, there were stories of residence advisors needing to stay up all hours because parties kept being moved throughout the night. In my third year, when Drink with Class was first introduced, it turned around so that residents were willingly telling resident assistants about parties and asking for help in keeping those parties under control."

Campus-community partnerships are also being developed to help promote healthier relationships with alcohol among students. Recognizing that campuses exist within the context of a larger community, the partnerships will work with partners such as bars, pubs and transportation systems.

"The Canadian Mental Health Association BC Division appreciates the continued investments in student mental health and well-being by the Ministry of Health," said Bev Gutray, CEO at CMHA BC. "The Changing the Culture of Substance Use project is an integral part of our work promoting student mental health across British Columbia, through Healthy Minds, Healthy Campuses. With continued government investment, and in partnership with CARBC, we have built a strong and active network of BC campuses focused on ensuring the conditions are in place to increase participation in, and completion of, post-secondary education for all students."

This investment aligns with the provincial government's 10-year mental-health and substance use plan, Healthy Minds, Healthy People, which focuses on prevention, early intervention, treatment and sustainability of mental health and substance use supports. The announcement meets a commitment within the plan to provide more substance use initiatives across the province.

The Province also offers Alcohol Sense, a comprehensive suite of online resources aimed at providing parents with tools to guide and educate their children to make healthy decisions about alcohol through critical thinking and conversation.

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 7:02 PM
To: Scheffel, Emile HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Re: As discussed - Hospice Funding

I'm ok with an event.

Terry Lake DVM
Minister of Health

On Jan 12, 2016, at 6:29 PM, "Scheffel, Emile HLTH:EX" <Emile.Scheffel@gov.bc.ca> wrote:

As far as I know, just made aware -- my impression is this course of action was decided a while back. I placed in the decision folder as we're looking for your direction to proceed with announcement.

If you have concerns, or would like more info, please let me know.

E

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:27 PM
To: Scheffel, Emile HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: Re: As discussed - Hospice Funding

This is not presented as a decision note. Am I being asked to approve the proposed designation of funds or just being made aware of it?

Terry Lake DVM
Minister of Health

On Jan 12, 2016, at 11:46 AM, "Scheffel, Emile HLTH:EX" <Emile.Scheffel@gov.bc.ca> wrote:

Minister,

Please see attached BN regarding Centre for Palliative Care. It's on your iPad under Approval > BNs for Decision.

Please let us know if you would like a briefing. Comms advises we could announce in February.

Thanks E

<1042945 - Funding to Support the Commitment to Double Hospice Spaces.docx>

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:49 PM
To: Brown, Stephen R HLTH:EX; Hughes, Doug J HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: 1038930 - Increasing Quality and Capacity for Care - FHA Plan.pdf
Attachments: 1038930 - Increasing Quality and Capacity for Care - FHA Plan.pdf; ATT00001.txt

Steve and Doug

Can we make certain the FHA brings nurses into the discussion early when contemplating nursing models of care changes?

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #1038930

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

TITLE: Increasing Quality and Capacity for Care: Fraser Health Authority Plan

PURPOSE: Fraser Health has proposed several strategies over the next few years that will improve quality and increase capacity in providing care for the residents of the health authority.

BACKGROUND:

Building on the work of the Fraser Health Strategic and Operational Review findings and the Strategic and Operational Plan and taking guidance from the Ministry of Health's (Ministry) system goals and policy paper, Fraser Health has developed a high level 2015/16 implementation plan "Increasing Quality and Capacity for Care". This plan focuses on year one of a multi-year plan that improves the quality and appropriateness of care, reduces unnecessary hospital use and shifts the organization towards a community-based system for health.

The strategies in this plan focus on making changes in both hospital and community care settings, while building partnerships with physicians and community organizations. Hospital-based strategies are required to address the immediate pressures of congestion, long lengths of stay, inappropriate use of acute care and unsustainable cost escalation. Improving the effectiveness of the hospital will enable investment in community-based services, which will increase the health authorities ability to provide the right level of care in the right location. Fraser Health is committed to establishing strong partnerships that enable integration along a continuum of care, resulting in a better experience for patients, clients and families.

DISCUSSION:

The first area of focus for this implementation plan is Improving Hospital Effectiveness, thereby making the very best use of the highly specialized hospital resources that are available. This includes strategies to reduce unnecessary hospital use and adopting a nursing team based model of care, which will allow the health authority to shift resources out of hospitals to locations that better meet patient needs and address the budget pressures.

1) Decreasing unnecessary hospital utilization

Building on work to decrease length of stay and hospital utilization that has been underway over the past year, local leadership and management teams are working in each community to decrease length of stay by:

- Increasing the use of best practices in patient care.
- Using case mix grouping (CMG) data to identify top CMGs that are not meeting length of stay targets and developing strategies to improve performance.
- Using structured unit-based reports and audits to increase performance and accountability for these measures.

1 of 3

Collectively, these efforts to reduce unnecessary hospital bed use will enable Fraser Health to realign resources to provide the right care in the right location.

2) Implementing Nursing Team Model of Care

Fraser Health is planning to adopt a nursing team based model of care by adjusting hours of care delivery and nursing team composition in selected medicine, surgery, and older adult units. To address how care is delivered to the patient and elevate the impact of the nursing team, this change implements a collaborative patient care model between RNs, LPNs, and HCAs (Health Care Assistants) that is consistent and standardized across the programs; Medicine, Inpatient Surgery, and Older Adult.

The second area of focus is Increasing Community Based Care. Building more capacity for care in the community will reduce pressure on the acute care system while providing patients with the right care in the right location. Short term strategies in this plan include targeted investments in proven community-based programs and services, which will help alleviate pressure on acute care. s.13,s.17

Increase Residential Care Capacity

Fraser Health will continue to build residential care capacity to meet the needs of the rapidly growing population that requires this level of care. This strategy includes additional residential care beds in several communities, beds to replace outdated facilities, and initiatives to ensure that individuals who are admitted in available beds meet provincial admission criteria.

Increase Primary and Community Care

Fraser Health is increasing community capacity by investing in services that have demonstrated effectiveness in avoiding or reducing hospital use, building partnerships with local Divisions of Family Practice and supporting innovation in care for Older Adults. Quality of care, health system sustainability, and patient/family centred care are driving system-wide changes that are shifting the locus of health care to community based services. Fraser Health is also participating in the Ministry of Health-led initiative Repositioning Health Care for Older Adults, with Langley and Abbotsford/Mission participating as prototype communities.

s.13,s.17

ADVICE:

s.13,s.17

Program ADM/Division: Doug Hughes/Health Services Policy and Quality Assurance
Telephone: 250.952.1049
Program Contact (for content): Michele Lane, ED, Acute and Provincial Services Branch
Drafter: Michele Lane
Date: December 14, 2015

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:45 PM
To: Scheffel, Emile HLTH:EX
Subject: ADTI

There is a decision note on this but I should get a briefing first.

Terry Lake DVM
Minister of Health

Scheffel, Emile HLTH:EX

From: Lake, Terry HLTH:EX
Sent: Tuesday, January 12, 2016 6:38 PM
To: Scheffel, Emile HLTH:EX
Subject: 1042868 - PCQRB Recommendation re Treatment of Low Acuity Patients in ERs.pdf
Attachments: 1042868 - PCQRB Recommendation re Treatment of Low Acuity Patients in ERs.pdf;
ATT00001.txt

Annotations in the attached document can be seen with Acrobat Reader on the computer. To view annotations on the iPad, use compatible app like PDF Expert.

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 1042868

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

TITLE: Patient Care Quality Review Board Recommendation Regarding Treatment of Low Acuity Patients in Emergency Departments

PURPOSE: To obtain a decision on the Ministry's response to a Patient Care Quality Review Board recommendation to dissuade patient use of Emergency Departments for low acuity ailments (Board File 14-100).

BACKGROUND:

- On July 17, 2015, the Fraser Patient Care Quality Review Board (the Board) completed its review of a complaint made on behalf of s.22
- s.22

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s.22

Following its review, the Board made the following recommendation to the Minister of Health: *That the Minister review this case to determine how best to ensure effective and efficient delivery of quality patient care for low acuity problems such as the epistaxis issue involved here, including by: a) enhanced public education about when to use ED facilities and when not to; b) enhanced information services for the availability of physicians and clinics to deal with low acuity problems; c) training programs and protocols for ED physicians and staff at the time of initial presentation at ED facilities by low acuity patients so as to encourage referrals to physicians or clinic services outside of the ED and without taking up ED time and resources.*

DISCUSSION:

- Reducing unnecessary ED visits and improving ED patient flow are existing Ministry priorities outlined in the 2014 document *Setting Priorities for the B.C. Health System* (pg. 25).
- Parts (a) and (b) of the Review Board's recommendation are already well addressed by provincial health information resources. Regardless of their health status, patients can access:
 - 8-1-1, a free provincial health information phone line where patients can speak with a nurse and get advice on whether to seek care at a local ED.
 - The HealthLink BC website, which provides detailed information about how and where to find health services in B.C.
 - The HealthLink BC "FIND Services" tool, which provides online mapping of urgent care and walk-in clinics, as well as navigation assistance for locating nearby health resources.

- The HealthLink BC "Smart Decisions" tool, which guides patients through key health care decisions by combining medical information with their personal values.
- Research indicates that public awareness campaigns regarding the use of emergency medical services have limited effect, as changes in public behaviour are not maintained beyond the end of the campaign itself¹. Sustained information resources, such as those outlined above, are strongly preferred to short term information campaigns.
- Part (c) of the Review Board's recommendation is not consistent with established clinical practices or professional accountabilities relating to patients seeking treatment in EDs:
 - ED staff assume responsibility for a patient once triage is complete. According to the Canadian Medical Association *Code of Ethics*, once responsibility for a patient is assumed, services must continue to be provided until they are no longer required or until another physician has taken responsibility.
 - ED staff cannot ensure a patient's safety if they advise them to seek treatment elsewhere. Conditions that present as low acuity may develop into significant concerns requiring immediate and comprehensive care that cannot be provide outside of a hospital setting.
- The Review Board does not offer strong evidence that treatment of epistaxis in EDs represents a significant provincial concern to the extent that a clinician training program would produce an exceptional return on investment^{s.22}
 - The Review Board found there were 2,238 cases of epistaxis treated at EDs in FHA between November 1, 2013 and October 31, 2014. However, presentations for epistaxis during this period accounted for only 0.4% of total ED visits across BC (see Appendix A).

OPTIONS (see Appendix B for Pros and Cons)

1. **Do Not Accept the Recommendation** – Inform the Board the Ministry will not implement the recommendation.
2. **Accept the Recommendation in Part** – Inform the Board that the Ministry will continue to address parts (a) and (b) of the recommendation through public information resources and initiatives relating to Emergency Department services, but will not implement part (c).

FINANCIAL IMPLICATIONS: No additional funds required for the recommended option.

RECOMMENDATION: Option 2.



Approved/Not Approved
Terry Lake
Minister of Health

Jan. 11, 2016

Date Signed

Program ADM/Division: Doug Hughes, ADM, Health Services Policy Division

Telephone: (250) 952-1049

Program Contact (for content): Brian Sagar, Director, Patient Safety & Care Quality

¹ Hodgson, et al. *Can Mass Media Influence Emergency Department Visits for Stroke?* Stroke. 107 – 1. Published online May 3, 2007

**Appendix A: Treatment Volumes for Epistaxis in BC Emergency Departments
(November 1, 2013 – October 31, 2014)**

Health Authority	Total ED Visits	Epistaxis Cases (as Presenting Complaint or Discharge Diagnosis)	Epistaxis as % of Total ED Visits
FHA	640,146	2,238	0.35%
IHA (KGH, RIH, PRH)	166,796	867	0.50%
NHA (UHNBC)	43,578	151	0.35%
PHSA (C&W)	43,458	154	0.35%
VCHA	328,061	1,336	0.40%
VIHA	-	Data unavailable	Data unavailable
Provincial Total	1,222,039	4,746	0.4%

Page 0926

Withheld pursuant to/removed as

s.13

Scheffel, Emile HLTH:EX

From: Heinze, Laura R GCPE:EX
Sent: Tuesday, January 12, 2016 8:09 AM
To: Scheffel, Emile HLTH:EX; Plank, Sarah GCPE:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: RE: CBCV: Miller - palliative care
Attachments: End-of-life care - Sept 2015_CM.docx; End-of-Life Care Supplemental - Sept 2015_CM.docx

Yup – here you go. Kind of the same thing ;)

For the record – no warning about the report. Will try to pull together some more specific KMs this am...

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:59 AM
To: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: RE: CBCV: Miller - palliative care

Sorry I mean palliative care

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:53 AM
To: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: Fw: CBCV: Miller - palliative care

Could you pls flip me our KMs on EOL care for this morning?

Thanks E

From: tno@gov.bc.ca
Sent: Tuesday, January 12, 2016 7:45 AM
Subject: CBCV: Miller - palliative care

CBCV (CBC Victoria)
CBC On the Island
12-Jan-2016 06:49

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TNO...

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CORE MESSAGING

Updated: September 2015

Ministry of Health

END-OF-LIFE CARE

- Premier Clark has given me a mandate to improve palliative and end-of-life care by building hospice capacity and partnering with those who support the health care system, and this important work is underway.
- Availability of palliative and end-of-life care becomes increasingly important as the population grows and ages.
- In future, the challenge of providing critical care services will become greater due to increasing numbers of people dying, increasing age of family caregivers and decreasing number of available caregivers.
- Our goal is to double the number of hospice spaces in B.C. by 2020.
- The ministry released the *Provincial End-of-life Care Action Plan for British Columbia* in March 2013. It was developed in consultation with clinical experts, community stakeholders, policy leaders and service providers and identifies three priority areas: delivery of timely co-ordinated end-of-life care; provision of education tools and resources to patients, caregivers and health care providers; and strengthening accountability and efficiency.
- At the same time, government, through the Provincial Health Services Authority, provided \$2 million to establish the BC Centre for Palliative Care.
- The centre is accelerating innovation and best practice in end-of-life care for people with life limiting illnesses by focusing on improving access to palliative care supports, enabling excellence through support for health professionals, and mobilizing citizen engagement to promote compassionate communities.
- In 2011, B.C.'s laws for incapacity planning changed to give capable adults more options to make their wishes for future health care known – including end-of-life care – by naming a representative and/or making an advance directive without needing to visit a lawyer or notary public.

- In 2012, the ministry led the implementation of advance care planning and advance directives in the province, and is currently working with the BC Centre for Palliative Care to refine the guide and develop tools and resources to facilitate their use.

Facts about End-of-life Care

- We know most people would prefer to spend their final days at home with friends and family around them. In 2014, about 56% of people who died of natural causes in B.C. spent their final days at home, in residential care or in hospice (compared to about 44% in 2003).
- The baseline measure for hospice spaces is 375 beds. As of March 2015, it consists of 87 acute/tertiary palliative care unit beds and 288 community hospice beds.
- Hospice spaces also include home-based palliative care services for those individuals who wish to die at home. Baseline measures and targets are being established.
- B.C. Palliative Care Benefits support B.C. residents who choose to die at home with the same drug coverage they would receive if they were in hospital, and with the necessary supplies and equipment.
- Approximately 88,000 patients have received these benefits since the program started in 2001. In 2014/15, \$17.5 million was spent on medications and pharmacy dispensing fees, up from \$3.9 million in 2001/02.
- We offer joint training for doctors and other health care professionals in palliative care. We also offer incentive payments to family physicians caring for patients with palliative needs.
- HealthLink BC also provides an after-hours palliative service, which provides triage and support to palliative care patients who are being cared for at home.
- End-of-life care is also identified as a priority under the Primary Health Care Charter.

Investment in hospice:

In 2015, we provided funding of:

- \$2.5 million to the Abbotsford Hospice Society to support the completion of Holmberg House, a new adult hospice.

In 2014, we announced funding of:

- \$40,000 to the North Thompson Valley Hospice House Society to conduct a feasibility study to develop hospice care.
- \$250,000 to the St. Joseph's Hospital Foundation to support four new hospice beds in Comox.
- \$40,000 to the Oceanside Hospice Society to help support end-of-life care services.

In 2013, we announced funding of:

- \$950,000 to Vancouver Hospice Society to allow the new hospice home to become fully operational.
- \$2 million to support a new, permanent home for Marion Hospice in Vancouver.
- \$2 million to Canuck Place Children's Hospice
- \$3 million for the expansion of Peace Arch Hospice in White Rock.

In 2012, we announced funding of:

- \$1.5 million to Canuck Place Children's Hospice

In 2011, we announced funding of:

- \$3.5 million to the Abbotsford Hospice Society

CORE MESSAGING

Updated: September 2015

Ministry of Health

END-OF-LIFE CARE SUPPLEMENT

- In addition to our Provincial End-of-life Care Action Plan for British Columbia, we are committed to double the number of hospice spaces in the province by 2020.
- Health authorities are working to meet that mandate.
- There will be 375 additional hospice spaces, which include dedicated and designated beds and home-based palliative care services in communities across the province.
- 61 beds are proposed for future roll out in each health authority, starting in April 2015, as follows:
 - Fraser Health: 15 beds
 - 10 beds at Holmberg House in Abbotsford (April 2016)
 - 5 beds at Peace Arch Hospice in White Rock (2018/19)
 - Vancouver Coastal Health: 12 beds
 - to be owned and operated by Providence Health care
 - Island Health: 24 beds
 - 8 beds in Comox and Parksville by Fall 2015
 - 3 beds in Campbell River (2016/17)
 - 2 beds in Sooke (2016/17)
 - 4 beds in Cowichan Valley (2017/18)
 - 1 bed in Mt. Waddington (2017/18)
 - 2 beds in Comox Valley (2018/19)
 - 1 bed in Oceanside (2018/19)
 - An additional 11 beds – location to be determined (2019/20)

- Interior Health:
 - Work is underway to determine strategies for optimizing Interior Health's existing bed stock to meet the needs of their rural and remote regions where stand-alone hospices have proved inefficient due to community size.
 - Based on current and projected growth, 30 locations have been identified as needing designated or dedicated beds.
- Northern Health: 10 beds
 - 2 in the Northeast
 - 4 in the Northwest
 - 4 in the Northern Interior

Scheffel, Emile HLTH:EX

From: Leake, Greg HLTH:EX
Sent: Tuesday, January 12, 2016 8:06 AM
To: Scheffel, Emile HLTH:EX
Subject: Re: VCH client complaint

Emile:

Thanks for the welcome! I'm looking forward to it.

Sorry it took a bit to get back to you -- I'm without either a laptop or an iPhone so far, so I'm tied to my desktop for email during the day. But this too shall pass!

Cheers,
G.

From: Scheffel, Emile HLTH:EX
Sent: January-11-16 4:32 PM
To: Downey, Gayle F HLTH:EX; Leake, Greg HLTH:EX; Docs Processing HLTH:EX
Cc: Stearn, Anne HLTH:EX; Andrachuk, Andrea HLTH:EX; McCormick, Erika HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: VCH client complaint

That would be great, thx!

E

-----Original Message-----

From: Downey, Gayle F HLTH:EX
Sent: Monday, January 11, 2016 4:32 PM
To: Scheffel, Emile HLTH:EX; Leake, Greg HLTH:EX; Docs Processing HLTH:EX
Cc: Stearn, Anne HLTH:EX; Andrachuk, Andrea HLTH:EX; McCormick, Erika HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: VCH client complaint

Yes, we will look into this Emile. Do you want a report back?

Kathy if you haven't already assigned, please direct to Anna-Maria. Thanks!

Gayle

-----Original Message-----

From: Scheffel, Emile HLTH:EX
Sent: Monday, January 11, 2016 3:42 PM
To: Leake, Greg HLTH:EX; Downey, Gayle F HLTH:EX; Docs Processing HLTH:EX
Cc: Stearn, Anne HLTH:EX; Andrachuk, Andrea HLTH:EX; McCormick, Erika HLTH:EX; Robertson, Derek HLTH:EX
Subject: VCH client complaint

Hey folks,

And welcome to the team, Greg.

Could I ask you to take a look at the below, have someone reach out to the client and to VCH if necessary?

Maureen Sexsmith
Robert and Lily Lee Family
Community Health Centre
#210-1669 E. Broadway
Vancouver BC V5N 1V9
December 16, 2015

s.22

For the Review Panel:

Re: Reassessment to provide adequate home care help so I will be safe in my home.

Introduction

s.22

Page 0935

Withheld pursuant to/removed as

s.22

Yours truly,

s.22

(1) Vancouver Community Mental Health Services , Clinical Policies and Procedures Manual, page 3: "vulnerable Adult; an individual who is physically and/or mentally disabled".

(2) Vancouver Community Mental Health Services, Clinical Policies & Procedures Manual: Neglect--Any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage to or loss of assets ...

s.22

Scheffel, Emile HLTH:EX

From: James, Ben <Ben.James@leg.bc.ca>
Sent: Tuesday, January 12, 2016 8:02 AM
Subject: Daily Outlook: Tuesday, January 12, 2016

Daily Outlook: Tuesday, January 12, 2016

BC Cancer Foundation Research Funding: At 10am in Vancouver, Premier Clark and Minister Lake announce funding to the BC Cancer Foundation to support research into Personalized Onco Genomics. Messaging and further details will be sent after the announcement.

Emergency Program Act Online Consultation Tweet:

- We want your input #BC! Provide your thoughts on updating the Emergency Program Act: <http://ow.ly/WV11Q> #PreparedBC

MSP Premiums Assistance Tweet:

- DYK approximately 800,000 British Columbians pay no MSP premiums at all? <http://ow.ly/WOa5d>

Blueprint Tweet:

- Seeking a new career in 2016? Many skilled trades are among the top 100 high-demand occupations: <http://ow.ly/WXkN2> #findyourfit

*Ben James
Director of Communications
BC Liberal Government Caucus
250-356-9131 (office)
250-208-7052 (mobile)*

From: Angela.Frattaroli@gov.bc.ca
Sent: Tuesday, January 12, 2016 7:08 AM
To: Frattaroli, Angela GCPE:EX
Subject: Health Hot Issues Summary - Tuesday, January 12, 2016

TNO Focus on - Health Hot Issues Summary

DO NOT FORWARD THIS E-MAIL TO ANYONE

Tuesday, January 12, 2016

Table of Contents

• **Mental Health and Addictions**

- Authorities urge caution after overdose spike - Tamara Cunningham - Nanaimo News Bulletin - 11-Jan-2016

Nanaimo authorities are urging drug users to take precautions after a spike in overdoses last week, including one suspected overdose death.

- Drug users told to take precautions - Craig Spence - Ladysmith Chronicle - 11-Jan-2016

RCMP and the Vancouver Island Health Authority are warning people who use street drugs to exercise 'extreme caution' due to a "significant increase in non-fatal overdoses in Nanaimo."

- Pollock - opiate overdose tracking - CBC Daybreak Kamloops - CBYK (CBC Kamloops) - 11-Jan-2016

Dr Sue Pollock reports the HIA is in the process of developing a proposal to create a system to track opiate overdoses in ERs

• **Public Health**

- Lake - KM pipeline decision - CHNL - CHNL (Kamloops) - 11-Jan-2016

BC's health minister Kamloops North-Thompson MLA Terry Lake says in government as in business you have to be consistent.

- Lake/Polak/Ranta - Trans Mountain pipeline - CHNL - CHNL (Kamloops) - 11-Jan-2016

BC's Health minister says the provincial government needs to remain consistent in terms of pipeline development proposals.

- Lake/Ranta - KM pipeline decision - CHNL - CHNL (Kamloops) - 11-Jan-2016

BC's Health minister and the MLA for Kamloops-North Thompson says it's all about meeting the province's five conditions for pipeline development.

- B.C. government will not support Kinder Morgan's pipeline bid - Kamloops This Week - Kamloops This Week - 11-Jan-2016

The B.C. government will not support Kinder Morgan's application to the National Energy Board.

• **Hepatitis**

- Hepatitis A outbreak - Global BC News Hour - CHAN (Global BC - Vancouver) - 11-Jan-2016

The BC Centre for Disease Control is monitoring a hepatitis A outbreak in Dawson Creek. Residents are also being urged to take steps to reduce the risk of transmission. [hlth]

- Hepatitis A outbreak in Dawson Creek, B.C. - CBC Online - CBC Online - 12-Jan-2016

Health authorities are monitoring a Hepatitis A outbreak in Dawson Creek, B.C. and trying to identify the source of the viral infection.

• **Interior Health**

- Mund/McLoughlin - Vernon walk-in clinics - CHBC News at 5:00 - CHBC (Kelowna) - 11-Jan-2016

Akbal Mund and Mike McLoughlin are raising concerns about the reduced hours of operation at Vernon's Gartree Medical Clinic

care, says a new study by the Canadian Cancer Society that calls on governments to make end-of-life care part of a new federal-provincial **health** accord.

- **Island Health**

- Island Health launches paperless record system in Nanaimo - Tamara Cunningham - Nanaimo News Bulletin - 11-Jan-2016

Patient records are about to go paperless as Island **Health** launches a new electronic medical record system in Nanaimo.

- **Residential Care**

- Small fire at Vancouver nursing home after resident burn threads off garment - CKNW Online - CKNW Online - 11-Jan-2016

Officials at Vancouver's St. Vincent's Langara nursing home say they are reviewing their policies with one of their residents after a small fire broke out in a room on Saturday afternoon.

- **HIV/AIDS**

- BR BC HIV - CP News - 11-Jan-2016

Infectious-disease experts in Indiana are calling on some renowned colleagues from British Columbia to address a massive H-I-V outbreak.

- **Assisted Dying**

- BR Assisted Death - CP News - 11-Jan-2016

The Supreme Court has yet to decide to grant the federal government an extension to come up with replacement legislation for doctor-assisted death.

- Judges seek compromise to allow doctor-assisted death - Sean Fine - Globe and Mail - 12-Jan-2016

In an extraordinary hearing on Monday, judges on the Supreme Court of Canada said there may be ways to permit a doctor-assisted death for grievously suffering individuals beginning next month, while also allowing the federal government the extra time it is requesting before the Criminal Code ban on assisted dying is lifted.

- Right-to-die issue back in front of top judges - Ian MacLeod - Vancouver Sun - 12-Jan-2016

The Supreme Court is once again deliberating whether irremediably ill Canadians with intolerable suffering should be denied their constitutional right to a doctor-assisted death while Parliament takes another six months to figure out how to decriminalize assisted suicide.

- Right-to-die issue may languish, fear activists - Kristy Kirkup - The Daily News (Nanaimo) - 12-Jan-2016

The new Liberal government may be taking the same laissez-faire approach to doctor-assisted death as its Conservative predecessors did, a lawyer for one of Canada's best-known right-to-die crusaders argued Monday.

- **Pregnancy**

- Ke - disturbing fetus discovery - Global News: BC 1 - Global News: BC 1 (Vancouver) - 11-Jan-2016

Grace Ke reports that RCMP are not treating the fetus discovery as a criminal investigation. The case has now been handed over to the coroner's office. [mjag, mcfd]

- Tim Hortons fetus - CTV News at Six - CIVT (CTV Vancouver) - 11-Jan-2016

RCMP in Chilliwack say the discovery of a human fetus in the washroom of a fast food restaurant will not result in a criminal investigation and has been turned over to the Coroners Service. [mjag, mcfd]

- Fetus found - The Province - 12-Jan-2016

RCMP say the discovery of a human fetus in the washroom of a Chilliwack fast-food restaurant will not result in a criminal **investigation**. A customer found the remains in a Tim Hortons washroom on Saturday afternoon.

- Fetus found in Tims bathroom - Times Colonist (Victoria) - 12-Jan-2016

RCMP in Chilliwack say the discovery of a human fetus in the washroom of a fast-food restaurant will not result in a criminal **investigation**.

- **Letters**

- Smokers should pay higher MSP premiums - Brian Wilkes - Times Colonist (Victoria) - 12-Jan-2016

- **Columnists**

- B.C. slams pipeline, leaves door open - Les Leyne - Times Colonist (Victoria) - 12-Jan-2016

The B.C. government bought itself more time on Monday to wait for pipeline politics to change, by trashing Kinder Morgan's plan to twin the existing Trans Mountain line from Alberta to Burnaby.

Mental Health and Addictions

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Authorities urge caution after overdose spike

Nanaimo News Bulletin

Monday, January 11, 2016

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By Tamara Cunningham

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Drug users told to take precautions

Ladysmith Chronicle

Monday, January 11, 2016

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By Craig Spence

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Pollock - opiate overdose tracking

CBYK

Monday, January 11, 2016, 08:12

By CBC Daybreak Kamloops

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Lake - KM pipeline decision

CHNL

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Lake/Polak/Ranta - Trans Mountain pipeline

CHNL

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By CHNL

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Lake/Ranta - KM pipeline decision
CHNL
Monday, January 11, 2016, 12:05
By CHNL

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Hepatitis A outbreak

CHAN

Monday, January 11, 2016, 18:31

By Global BC News Hour

Hepatitis A outbreak in Dawson Creek, B.C.

CBC Online

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Mund/McLoughlin - Vernon walk-in clinics

CHBC

Monday, January 11, 2016, 17:05

By CHBC News at 5:00

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Palliative Care Report

CP News

Tuesday, January 12, 2016

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Palliative care inadequate

Globe and Mail

Tuesday, January 12, 2016

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By Elizabeth Church

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Island Health launches paperless record system in Nanaimo

Nanaimo News Bulletin

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By Tamara Cunningham

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[Residential Care](#)

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Small fire at Vancouver nursing home after resident burn threads off garment

CKNW Online

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Assisted Dying

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Judges seek compromise to allow doctor-assisted death

Globe and Mail

Tuesday, January 12, 2016

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By Sean Fine

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Right-to-die issue back in front of top judges

Vancouver Sun

Tuesday, January 12, 2016

Page B03

By Ian MacLeod

Right-to-die issue may languish, fear activists

The Daily News (Nanaimo)

Tuesday, January 12, 2016

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By Kristy Kirkup

Ke - disturbing fetus discovery

Global News: BC 1

Monday, January 11, 2016, 11:11

By Global News: BC 1

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Pregnancy

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Tim Hortons fetus

CIVT

Monday, January 11, 2016, 18:01

By CTV News at Six

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Fetus found

The Province

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Fetus found in Tims bathroom

Times Colonist (Victoria)

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Smokers should pay higher MSP premiums

Times Colonist (Victoria)

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By Brian Wilkes

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Letters

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Health care system a well-oiled machine

Prince George Citizen

Columnists

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B.C. slams pipeline, leaves door open

Times Colonist (Victoria)

Tuesday, January 12, 2016

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By Les Leyne

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Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 7:05 AM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: News Releases and Issues for Today
Attachments: DRAFT.PDF

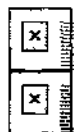
Minister,

Here are the health news releases and issues for today.

Derek

Office of the Premier / Ministry of Health

Supporting miracles with Personalized Onco-Genomics – (10 am release) It's not every day a miracle happens. With government funding of \$3 million to the BC Cancer Foundation, the Personalized Onco-Genomics program and high priority cancer projects are receiving a boost from the BC Cancer Foundation to help the BC Cancer Agency continue to find unique cures for the hardest to beat cancers, Premier Christy Clark announced today. – Premier Christy Clark and Minister Lake quoted



There are no health issues for today.

Scheffel, Emile HLTH:EX

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 7:04 AM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: Tweets for Tuesday, January 12
Attachments: DRAFT.PDF

Good Morning Minister,

Here are your tweets for today.

Derek

Office of the Premier / Ministry of Health – Personalized Onco-Genomics (tweet after 10:30 am)

Before:

Touring the @BCCancer_Agency with @christyclarkbc. Amazing to see some of BC's finest researchers at work. [Insert photo] (130 characters w/ photo)

After:

Supporting personalized cancer treatment & #BC's finest researchers. <http://ow.ly/FNY0t> @christyclarkbc @BCCancer_Agency @bccancer #POG (139 characters)



CAUCUS TWEETS (Emile as prepared a News You Can Use)

\$3M funding 4 personalized cancer treatment. <http://ow.ly/FNY0t> @christyclarkbc @BCCancer_Agency @bccancer #POG [insert photo] (140 characters w/ photo)

Supporting personalized cancer treatments. <http://ow.ly/FNY0t> @christyclarkbc @BCCancer_Agency @bccancer #POG [insert photo] (138 characters w/ photo)

A boost for those with the most aggressive/recurring forms of cancer. <http://ow.ly/FNY0t> @christyclarkbc @BCCancer_Agency @bccancer #POG (140 characters)

Alzheimer Awareness Month (tweet anytime)

#StillHere is the social media handle being promoted by the Alzheimer Society

For #Alzheimer Awareness Month help end the stigma associated with all forms of dementia. @AlzheimerBC #StillHere (113 characters)

During #Alzheimer Awareness Month take the quiz to test your basic knowledge of dementia.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 5:04 PM
To: Poilievre, Tricia HLTH:EX
Cc: Marr, Ann HLTH:EX
Subject: RE: Health Ministers' Meeting Materials

Great, thanks!

From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 5:03 PM
To: Scheffel, Emile HLTH:EX
Cc: Marr, Ann HLTH:EX
Subject: Health Ministers' Meeting Materials

Hi Emile,

Please find attached the following materials for the Minister in preparation for the Thursday briefing:

- At a Glance Agenda
- Conference Information e-binder (this includes the itinerary)
- Jan 20 – PT HMM e-binder

Health Canada has just sent out the full package of briefing documents, so we will send a binder for the FPT day early tomorrow. We have requested materials on the separate meetings the Minister is attending (CFNU, CMA, e-cigarettes) and will add those to the e-binders as soon as they are received.

For the e-binders, he can navigate through the documents using bookmarks. We're also happy to pull out individual documents separately, if he prefers. If you have any questions, please let me know.

Thanks!

Tricia Poilievre

A/Director | Intergovernmental Relations | Ministry of Health, BC
Office: 250 952-1304 | Cell: 250 415-2639 | tricia.poilievre@gov.bc.ca

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 4:52 PM
To: Mills, Shane LASS:EX
Cc: Dhanowa, Damon HLTH:EX; Robertson, Derek HLTH:EX
Subject: Media request - CBC - duty to report medication adverse events

CBC is asking about a Health Professions Review Board decision from 2014, where a patient died from adverse drug reactions.

[http://www.hprb.gov.bc.ca/decisions/2014-HPA-106\(a\);2014-HPA-107\(a\);2014-HPA-108\(a\).pdf](http://www.hprb.gov.bc.ca/decisions/2014-HPA-106(a);2014-HPA-107(a);2014-HPA-108(a).pdf)

The recommendation that they are asking us about is around the Ministry enacting legislation to require that all professions licensed under the Health Professions Act be required to report cases of adverse medication outcomes, at least in situations where there was a serious harm or death resulting.

Our program folks are not familiar with this recommendation, but will look at it and consider it. The response below has gone to MTL for approval.

Program is still looking into it to see if there is any other info we can provide.

E

Topic:

HPRB decision around legislating requirement of all health professions to report cases of negative drug interactions

Suggested response:

"There is currently no specific requirement of this kind in the HPA. The Ministry is aware of this recent decision of the HPRB, and is considering the recommendations it contains."

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 4:49 PM
To: 'Badger, Derek [JOICA]'
Subject: RE: Janssen (J&J) Letter to Minister Lake

Derek Robertson (EA) and I will both be there.

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jnj.com>]
Sent: Tuesday, January 12, 2016 4:48 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

OK, thanks.

Do you know who from your office will be accompanying the Minister at the FPT meetings next week?

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Badger, Derek [JOICA]
Subject: RE: Janssen (J&J) Letter to Minister Lake

I would love to know! No intel just yet.

From: Badger, Derek [JOICA] [<mailto:dbadger@its.jnj.com>]
Sent: Tuesday, January 12, 2016 4:20 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks Emile, that would be great if you could connect me with the new CoS and MA when they are in place.

Do you know when they might be in place? Anyone I might already know from another Minister's office?

Appreciate your help with this.

Derek

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: Tuesday, January 12, 2016 4:16 PM
To: Badger, Derek [JOICA]; Merrifield, Katy PREM:EX
Subject: RE: Janssen (J&J) Letter to Minister Lake

Thanks for this, Derek. Happy new year to you, too.

Katy has moved on to a new role in the Premier's Office, and I will be transitioning out as well at the end of the month.

If I may, I will connect you with the new chief of staff once they are appointed to continue this conversation.

Best,

E

As an FYI, I just wanted to share a letter that has been sent from my President to Minister Lake, sharing our position on National Pharmacare in advance of next week's Health FPT meetings in Vancouver. Let me know if you have any questions or concerns – happy to discuss at your convenience.

Will either of you be attending the Health FPT meetings next week? I will be in Vancouver and would love the opportunity to briefly bring you up-to-speed on the status of our 'Biologics Portfolio Proposal' that we discussed back in October. Let me know if that might work – if not, perhaps we can find a few minutes over the phone sometime soon.

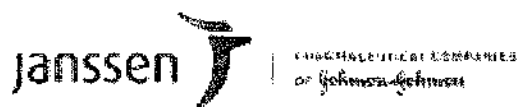
Thanks so much,

Derek Badger

Manager, Government Affairs and Policy

Office: 250.770.1600

Mobile: 250.486.0194



Q's and A's

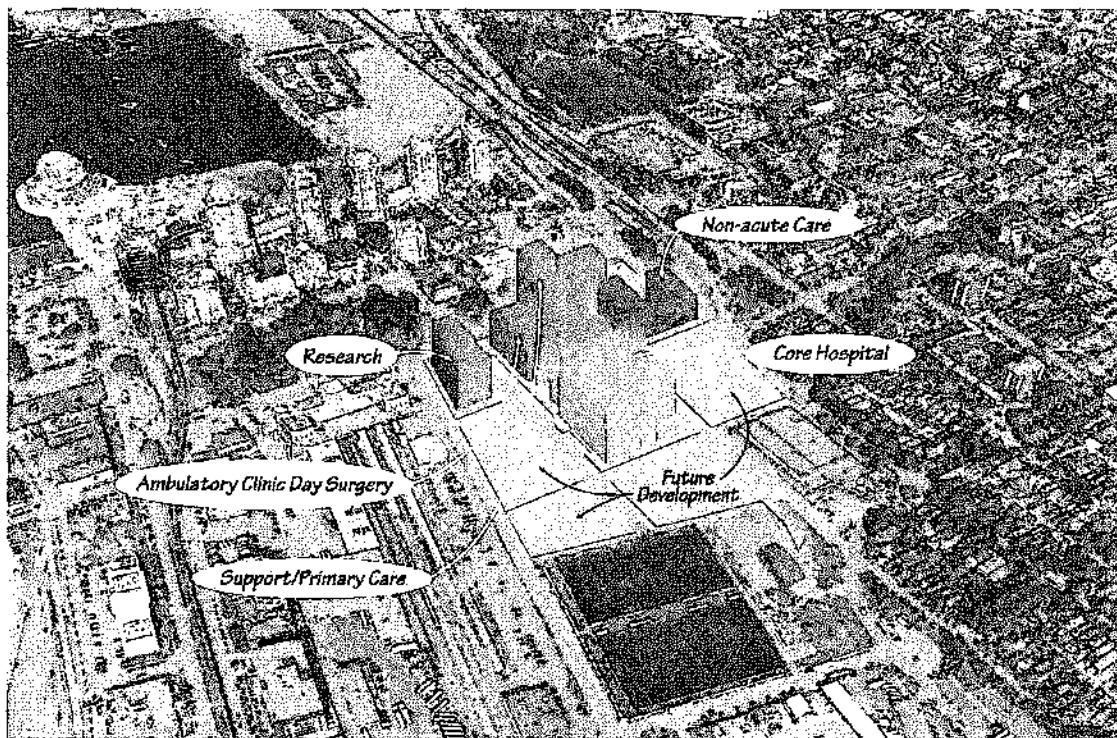
1. What are you announcing?

Announcement – The Ministry of Health and Providence Health Care are announcing the launch of an exciting new project for St. Paul's Hospital and exceptional patient-centred care for British Columbians. We're renewing St. Paul's as a brand new hospital and integrated health centre complex built from the ground up at our Station Street site.

- **Core Hospital** – The core of the transformation is a completely new St. Paul's as a hub of a world-class integrated care, research, and teaching centre, providing core critical care and acute services at a new site.
- **Connected to Integrated Health Centre** – This hospital complex will be connected to a health centre of community and primary care services to serve the most vulnerable patients, especially those suffering from mental health and addictions illnesses, and the elderly.

The new hospital will continue as one of British Columbia's two most specialized hospitals for adults. It will also be at the centre of a network of new and existing dedicated primary care services in the region, including services that will be set up for the West End.

In addition, as part of the Station Street development, Providence will look at building a number of social housing units to provide affordable housing options for Vancouver residents.



Key Clinics/Community Services to Continue – The redevelopment planning will include consultation on the continuation of key primary health services at the existing St. Paul's site or in the West End.

Business Plan/Consultation Process – We will begin a Business Plan development process and comprehensive consultation activities to engage with all stakeholders. Our work and learnings from the previous concept plan will help inform the new planning process.

Cost – The Ministry of Health will provide \$500M and Providence Health Care will contribute the rest of the cost (non-taxpayer money, leveraged from Providence's land assets and through the donor/philanthropic community), which will be determined by a Business Case process.

Catalyst – The new St. Paul's will be a catalyst for helping realize the Ministry of Health's new vision for providing patient-centred acute, primary, ambulatory and community care for all, especially the most vulnerable patient populations: those suffering from mental health and addictions, aging and end-of-life issues.

Strengthening Networks of Care – The plan further builds on St. Paul's current provincial leadership role and proven reputation in key areas – including heart, lung, kidneys and HIV/AIDS – by developing centres of excellence in addictions, mental health, aging and seniors' care.

The bottom line is this new facility is much more than a hospital. We are expanding access to community care and a network of primary clinics with a goal of putting the patient first.



2. How does this fit into the ministry strategic vision of care?

The new St. Paul's and integrated health care centre will be designed in a way that puts the patient at the centre. This will be much more than a hospital as there will be a focus on expanding community access and treatment.

The plan fits into the ministry's strategic vision of improving primary, community and residential care while investing in services for those with moderate to severe mental illness, dementia and chronic care concerns.

St. Paul's Hospital is an important part of the network of hospitals in the Lower Mainland, serving a large and growing population from downtown Vancouver, and from across the region.

We wanted to make sure that the revitalized hospital fits within the future long-term vision of health care in the region and across the province, focusing on more comprehensive community services and a partnership between Lower Mainland hospitals.

While our acute care system does an excellent job of caring for people when they are very sick, we need to shift our planning priorities into caring for people before they reach that stage of illness.

We are looking at our services, programs and resources through the patient lens – asking ourselves what supports we need to help our population remain healthy and at home and, when they are ill, what we can do to support them to receive care in their community.

The new St. Paul's campus will bring to life the province's new vision for providing better patient-centred that is anchored by strong community and primary care – bringing acute, primary, ambulatory and community care on a single campus.

The facility will be something the local community and the entire province will be proud of for years to come.

3. What's so special about this proposal?

Revitalize Health Care – The new St. Paul's at Station Street will revitalize the system of health care delivery to provide the latest – and best – care in the right place to more people, quicker, cost effective and with improved outcomes.

Benefits BC Taxpayers – And it's beneficial to BC taxpayers. The provincial government will provide \$500M, while Providence Health Care will contribute the rest (to be determined through Business Plan) through leveraging our land assets and with the help of fundraising.

Exciting New Care Solutions/Improve Patient Flow – This redevelopment will strengthen and integrate every patient's care path – from the hospital to the community to home – taking full advantage of St. Paul's range of provincial and community services and working closely with other health partners

We will be able to have focused care plans supported by dedicated care teams for each patient.

The new St. Paul's will give patients a 24/7 centre to go to that will have a centralized intake process. It will determine which patients require hospital care, which require primary, community or other specialist care or supports. They will be directed onto the right care paths, quickly and efficiently, resulting in less congestion, faster treatment, and better use of taxpayer dollars.

Details of Core Hospital and Adjoining Integrated Health Centre – There are two main components proposed: A Core Hospital **plus** an attached Integrated Health Centre

- Core Hospital – Brand new hospital looking after the most acute patients to include:
 - Tertiary/Quaternary programs such as cardiac, renal care, specialized and complex surgical services
 - Higher percentage of single-patient rooms to minimize infections and maximize privacy
 - Emergency and critical care
 - Brand new technologies and designs
- Integrated Health Centre – A separate but connected campus, with:
 - A new, full-service critical care hospital
 - 24/7 primary care services
 - Chronic disease management services
 - Mental health and addictions beds and programs
 - On-site residential care beds and programs
 - Ambulatory services and outpatient clinics
 - Non-acute medical services
 - A low-risk birthing centre
 - End-of-life care
 - Research and teaching
 - Community Care
 - Community Outreach Programs

4. Can you expand on the primary care plan?

Good and continuous primary care is at the centre of any high quality, highly functioning health care system -- particularly for those with highly complex needs or chronic conditions.

In Vancouver, there are a number of very good integrated primary care centres that cater to this highly complex patient need. As this project is developed and the new hospital is built, this network will be linked to the new and existing hospitals to ensure that patients receive the best possible care where they are.

5. What happened to the plan to rebuild at the current St. Paul's location on Burrard Street?

Last Plan Falls Short – We worked comprehensively on the concept plan for that proposal and although it had some good ambulatory care solutions, the plan fell short of meeting the standards required for patient-centred care.

Our comprehensive concept plan document for that option demonstrates we were serious about looking at it; but the more we delved into it, the more we couldn't realistically make the case for its development, especially at a cost of \$850 million. The Station Street solution – integrated with satellite components of care across the region and a strong primary care presence on the site next to the hospital – made the best sense for the community and the province.

New Solution is Best Practice – St. Paul's serves a diverse population, local and provincial. In addition to exceptional critical and acute care, the Station Street solution allows for best practices and the latest thinking to keep people healthy through prevention, chronic disease management, primary care, community care and focused non-hospital-based services for mental health, addictions, and seniors needs.

There are **numerous challenges** with the older proposal:

- Full renewal could take up to 15 years;
- Patients wouldn't end up with a high percentage of single-patient rooms, leaving patients vulnerable to infections and lack of privacy; the concept plan for Burrard provided for a 48% of single-patient beds;
- There was no ability to expand for the future, with the current site's 6.5 acres (compared to Station Street's 18.5 acres);
- Patients wouldn't benefit from full renewal of all the acute-care programs and facilities;
- Seismically upgrading the site and all other construction would have had to occur while the hospital continued to operate, and the disruption to patient care and the neighbourhood would have been a major challenge.
- Patients wouldn't get the benefits of a hospital designed and constructed as an integrated facility, as upgrades would have to be done one at a time over many years;
- A solution at the Burrard site will be inefficient, both economically and from a care-design perspective, because upgrades will be done piece-meal, over many years. A brand new build can be designed with the most effective and efficient patient-care solutions.
- And Providence Health Care, wouldn't have the ability to raise enough money to pay for the cost above the \$500M investment from government because of a lack of donor interest (due to the long timelines) and inability to fully take advantage of the value of our lands.

Brand New Build – The successful implementation of this transformation requires an entirely new build –“from scratch” – on land that can adequately accommodate the proposal.

Distance and Driving Times – For that reason, the 18.5 acres of available land at Station Street in the heart of Vancouver has been identified as the location. It is a relatively short distance from the current site: 2.9 kms from the current St. Paul's location – an 8-minute drive by car (10 minutes in traffic). [Source: Google Maps]

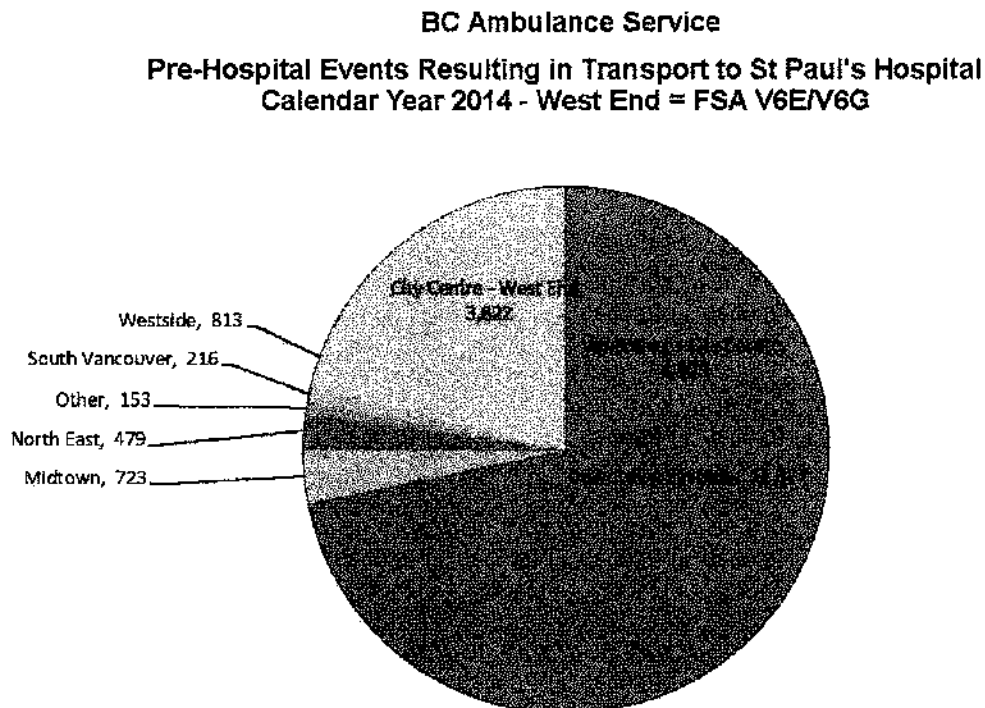


6. But by moving St. Paul's Hospital away, aren't you endangering the lives of patients by increasing ambulance travel times? Won't people requiring emergency treatment be harmed? We need an emergency department nearby in our neighbourhood so we can walk there if we need.

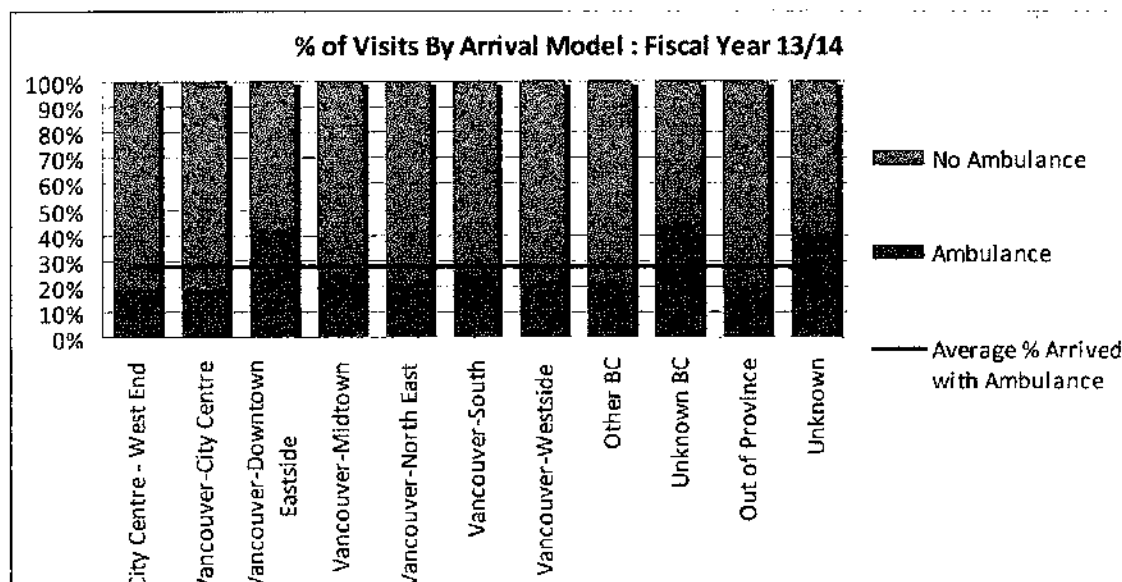
Hospital Locations Not Decided by Specific Neighbourhood – Accessibility to hospital and emergency care is extremely important, yes. But hospitals don't serve any one neighbourhood, otherwise every neighbourhood and every community would want or have one, which is not sustainable.

Must Call an Ambulance – The best thing anyone can do in a health care emergency is call an ambulance. Paramedics determine which hospital is best to take the patient. It's all dependent upon the patient need. It could be, for example, that a patient is one block away from St. Paul's, but the patient may be taken to Vancouver General because that's where the specific condition or trauma is best treated (for example if it's a spinal or brain issue, VGH has the designation and specialized services to provide that care).

Data for ambulance pick ups and drop offs at St. Paul's shows that the West End and downtown Vancouver areas do have a good number of ambulance pick-ups – 17% and 20% of total ambulance visits respectively – but significantly less when compared to pick-ups from the Downtown Eastside, which account for almost 52%:



LHA-FSA	Events	%
Vancouver - City Centre	4,403	20.0%
Downtown Eastside	11,377	51.7%
Midtown	723	3.3%
North East	479	2.2%
Other	153	0.7%
South Vancouver	216	1.0%
Westside	813	3.7%
City Centre - West End	3,822	17.4%
Total	21,986	100.0%



	14/15 YTD		14/15 YTD
	Ambulance	No Ambulance	Total
City Centre - West End	18%	82%	100%
Vancouver-City Centre	18%	82%	100%
Vancouver-Downtown Eastside	42%	58%	100%
Vancouver-Midtown	25%	75%	100%
Vancouver-North East	22%	78%	100%
Vancouver-South	23%	77%	100%
Vancouver-Westside	22%	78%	100%
Other BC	21%	79%	100%
Unknown BC	43%	57%	100%
Out of Province	20%	80%	100%
Unknown	40%	60%	100%
Total	27%	73%	100%

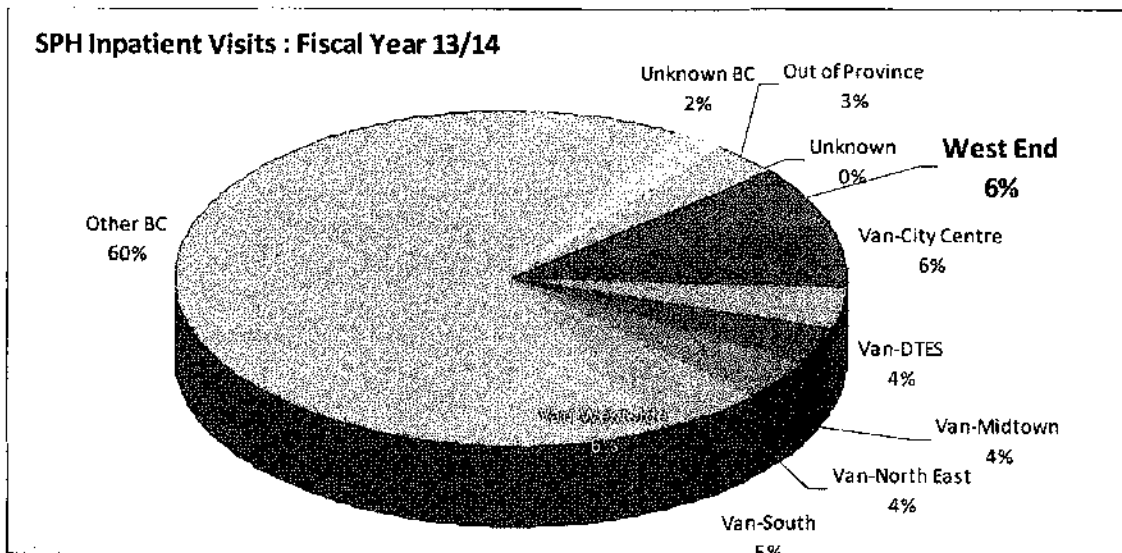
Need for Right Care for Each Patient – There are numerous “walk-in” patients into emergency rooms, but, statistics show, a high number of them are not in need of high-priority emergency care (high priority patients are termed CTAS 1, 2 or 3, and lower priority are termed CTAS 4 or 5; CTAS stands for Canadian Triage and Acuity Scale, which goes from 1 to 5).

Centralized Triage – One of the key benefits of the new redevelopment will be a centralized 24/7 triaging access point that will ensure fast access and flow of patients showing up for care at the hospital. The central intake will quickly put CTAS 4s and 5s into the campus of care part of the facility, while 1s, 2s and 3s are taken into the emergency department.

Transportation Options – Part of the public consultation process will look at which options can help improve access to the new hospital for West End residents. We will look at the feasibility on how to best connect the new site with the West End, and any transit options that could be possible.

West End Patient Use for St. Paul's – Most of St. Paul's admitted patients (as much as 60%) come from outside of the City of Vancouver. West End patients of course use the hospital for many needs. The following points and pie-graphs summarize some of the current usage for St. Paul's by West End residents:

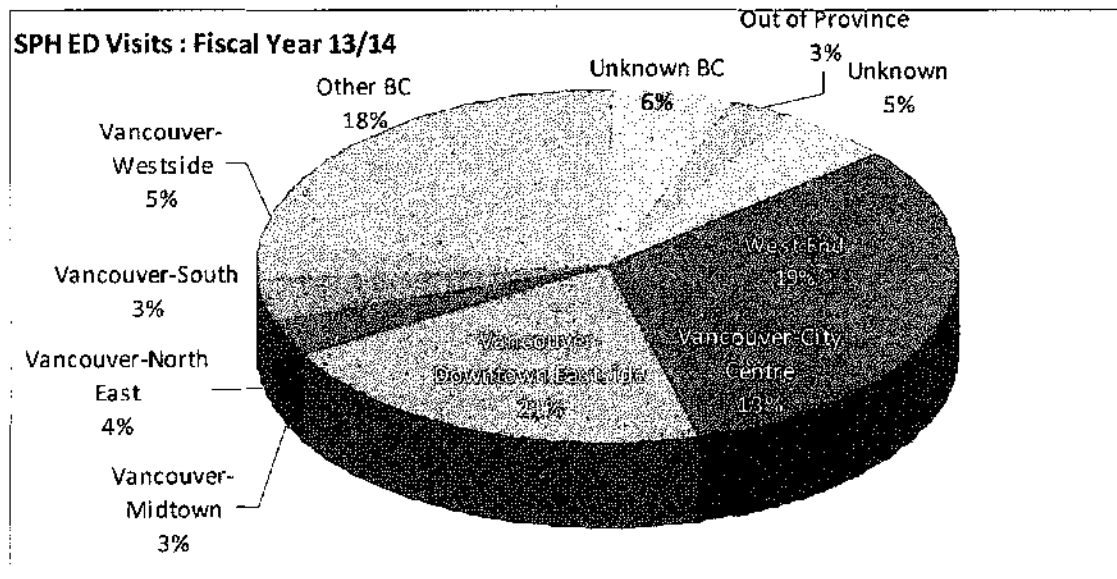
- With regard to the total number of inpatients (those admitted into a hospital bed), the outpatients (those who are treated in the hospital and released on an outpatient basis) and clinic-visit patients that come to St. Paul's for various appointments – of these about 6% to 9% are from the West End.
- Of the total number of patients that come into the Emergency Department at St. Paul's, about 19 per cent – about 13,300 total – are from the West End (for comparison, about 21 per cent are from the Downtown Eastside).
- Of these 19 per cent coming to Emergency, about 82 per cent are walk-ins. And of these 19 per cent, about 11 per cent – or approximately 300 – are admitted into the hospital.
- 60 per cent of patients admitted into St. Paul's are actually from outside the City of Vancouver.



Inpatient Visits (Direct Admissions)

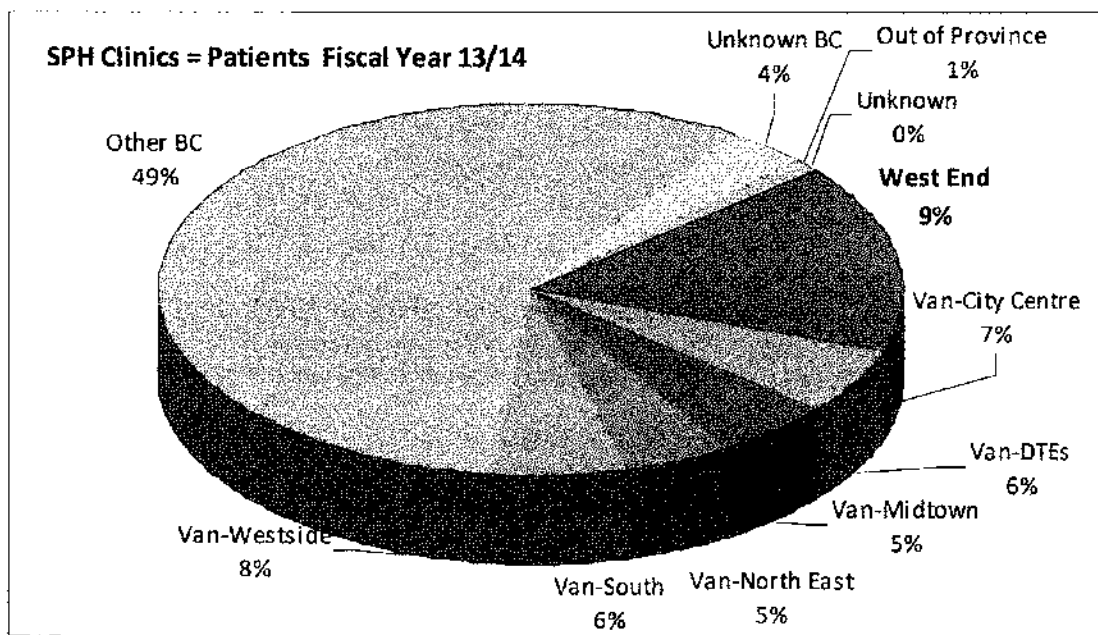
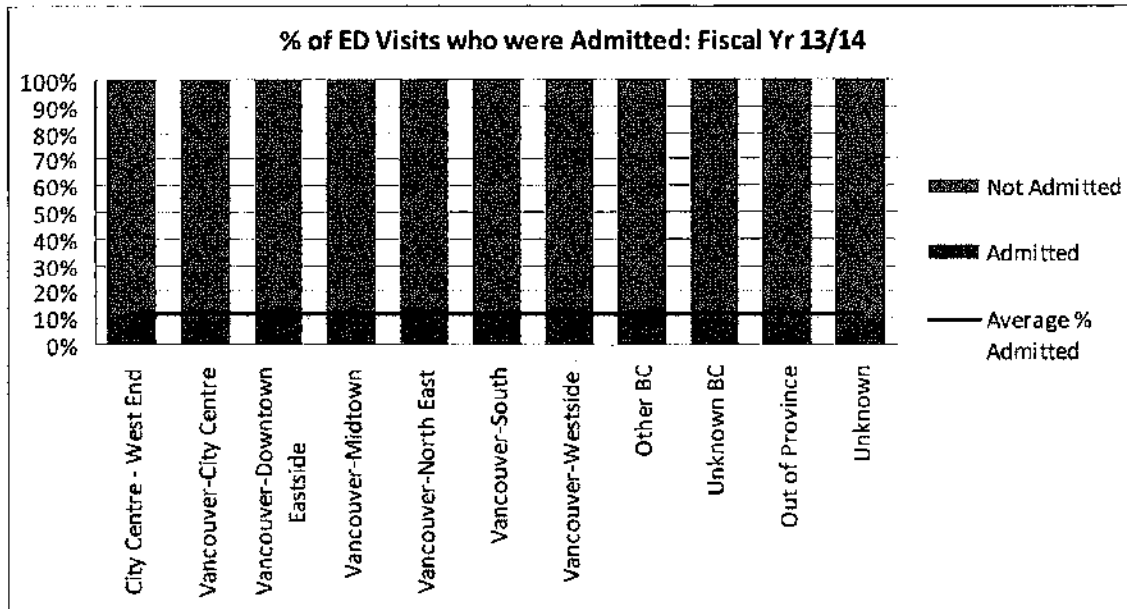
Volumes	12/13	13/14	14/15 YTD
City Centre - West End	441	451	369
Vancouver-City Centre	426	415	324
Vancouver-Downtown Eastside	266	284	232
Vancouver-Midtown	261	268	193

Vancouver-North East	262	282	183
Vancouver-South	332	354	228
Vancouver-Westside	426	447	280
Other BC	4209	4331	3021
Unknown BC	153	181	160
Out of Province	206	231	155
Unknown	16	12	15
Total	6998	7256	5160



ED Visits

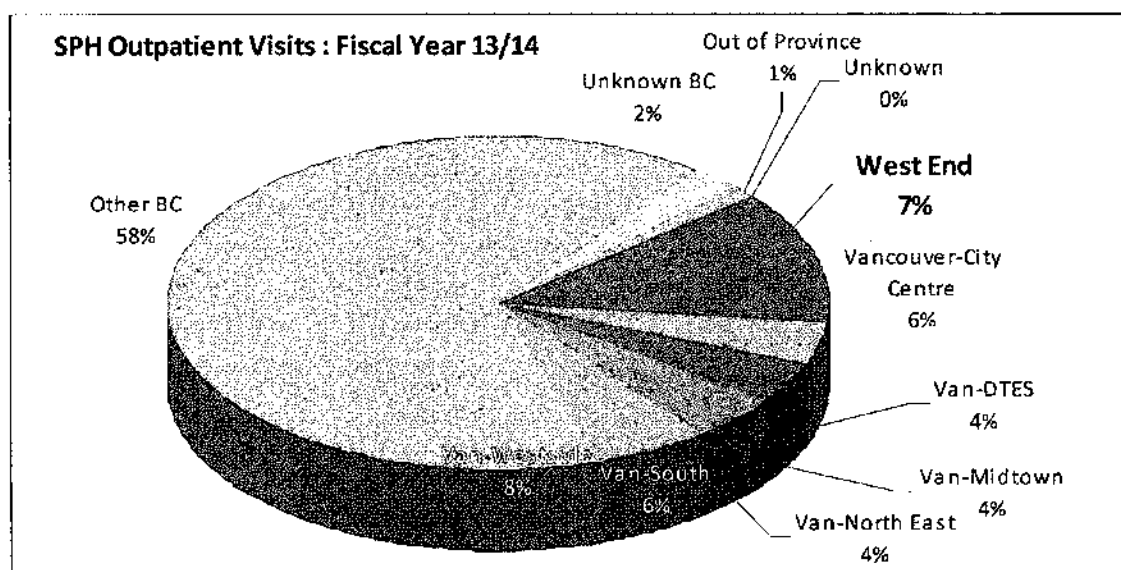
	12/13	13/14	14/15 YTD
City Centre - West End	14095	15132	13318
Vancouver-City Centre	9611	10026	8983
Vancouver-Downtown Eastside	15786	16306	14079
Vancouver-Midtown	2355	2635	2526
Vancouver-North East	2860	3074	2677
Vancouver-South	2332	2438	2183
Vancouver-Westside	3988	4073	3692
Other BC	13996	14247	12256
Unknown BC	4077	4428	4986
Out of Province	2006	2163	2153
Unknown	4941	4177	2825
Total	76047	78699	69678



Clinics (# of Patients accessing)

	12/13	13/14	14/15 YTD
City Centre - West End	4042	4294	3471
Vancouver-City Centre	3047	3096	2540
Vancouver-Downtown Eastside	2687	2725	2245
Vancouver-Midtown	2091	2288	1943
Vancouver-North East	2085	2078	1697
Vancouver-South	2375	2670	2161
Vancouver-Westside	3409	3569	3093

Other BC	22413	22563	18283
Unknown BC	1582	1593	1398
Out of Province	390	434	367
Unknown	82	77	67
Total	44203	45387	37265



7. You are moving a hospital that has been part of neighbourhood for decades. What will you leave behind? How will you address the health care needs of neighbourhoods once the hospital is not there anymore?

Key Clinics/Community Services to Continue – The renewal is about providing the latest and best care to all patients that rely on St. Paul's, no matter where the hospital is located. Additionally, community consultation will be done with the surrounding neighbourhoods of the hospital to determine which primary care and community care services and clinics need to be left at the existing site or in the West End.

Future land use of the current hospital site could include a mixed use downtown development, consistent with City of Vancouver policies.

St. Paul's is a Community and Provincial Resource – We acknowledge that hospitals are an important part of a neighbourhood. However, hospitals such as St. Paul's serve the needs of patients from throughout the province. British Columbians deserve the best care possible; that means investing in new health infrastructure that can best meet the needs of many communities and the province as a whole.

West End will Continue to Benefit from New Hospital/Campus – The West End and surrounding neighbourhoods will continue to benefit from renewal at Station Street. Additionally, community consultation will help determine what other needs

the neighbourhood will have and what options can be looked at for meeting those needs.

SPH Needs Complete Renewal – St. Paul's is aging and challenged; it was built based on infrastructure and care designs of the past, and simply retro-fitting the hospital various buildings will cost hundreds of millions and not produce the right care outcomes for patients.

New Investment will Lead Canada – We now have an exciting and forward-thinking project; one that will give us a research, teaching and care hospital of the future and a health care campus unrivalled in Canada.

8. What about your other acute care hospital – Mount Saint Joseph? How does it fit into your plans and what about its needs?

Ideal Opportunity to Include MSJ In Planning – This is a great chance for MSJ to contribute to the new integrated model of care and further strengthen its program delivery. MSJ is also an aging hospital and has many needs. Providence's master plan to upgrade the hospital calls for up to an additional \$150 million over the next decade to maintain its operations. Its emergency department (ED) has outgrown its original capacity. The ED was built for 12,000 patients a year and is now seeing 25,000.

MSJ has close programmatic links with St. Paul's. We will look for opportunities to find better, and longer term, solutions for MSJ's challenges. In the short and immediate terms, MSJ site leaders are continuing to implement solutions to reduce emergency department congestion and improve patient flow at the hospital.

9. Even if the new hospital is built at Station Street, it will take years to complete. What will you do about the current infrastructure issues at St. Paul's?

Safe Operations Ensured – All provincial health facilities are managed to ensure safe operations. Annual allocations for upgrades and capital investments are made on a priority basis. St. Paul's has benefited with over \$90 million of infrastructure investments since 2001. For example, the provincial government advanced funding for two upgrade projects in 2012 – a major electrical project to replace a main switch gear, transformers and emergency generators, and an elevator upgrade project. The elevator upgrade is underway.

The same needs-assessment processes will continue for St. Paul's until the new development is complete.

10. Why didn't you tell the public that the Station Street option was once again being considered seriously? When did you make this decision? Why didn't you consult the public once the last Concept Plan was finalized?

Option Always Available – The Station Street option has always been available, since it was first publicly discussed over 10 years ago. We have repeatedly looked at renewing at the current site and there are too many barriers to providing the right care to patients.

Renewal at Existing Site Not Best for Patient Care – As stated, the more we discussed the concept plan for the current-site renewal, the more it became apparent over the past year that it's a very challenging option and far from an optimal solution, prompting us to re-look at the Station Street option.

Opportunity for Consultation – As stated, it became very apparent that the solutions in the last Concept Plan were lacking. It was felt a consultation process on this plan would not be a prudent use of taxpayer resources. The plan is being released so people can review it. We will be doing comprehensive public consultation and expect a robust discussion on all aspects, pros and cons of ideas about St. Paul's Hospital redevelopment.

Station Street Right Solution – We are confident the solution we will now develop into a Business Case – with much public and stakeholder input and engagement – is the right one for the British Columbians.

11. Will any of this mean a cut to health care services or job losses? Does it mean less hospital beds?

It's About Improved Care, Not Cuts – This redevelopment is about putting patients at the centre of care, integrating networks of care services in Vancouver and beyond, improving services, improving access, providing the latest and the best care available in the world for patients and families; it's about enabling state-of-the-art research; it's about ensuring our next generation of health care students (medical, nursing, etc.) learn and benefit from the latest care pathways, latest technologies and designs. It's about providing nurses, doctors, researchers, volunteers and all health care staff with a safe and futuristic place of providing care.

St. Paul's Infrastructure is Outdated – Although there's great care being provided currently at St. Paul's Hospital, it was designed decades ago. Its current infrastructure, layout, its patient rooms and care pathways are all outdated.

Not About Number of Beds, But What Kind – The kind of care models developed for the programs and services – including the number of beds required – will all be part of the program and clinical planning through the Business Case development process. We're looking at a care transformation that looks at addressing people's health needs before they get worse and end up in a hospital. It's about prevention, wellness and improved primary care. It's about the right care to every patient in the right setting. That will mean looking at what kind of beds or patient spaces are needed where to ensure patient-centred care, accessibility and best fit for the integrated care models.

12. On June 12, 2012, Premier Christy Clark announced the redevelopment of St. Paul's would occur at its current site. Isn't this a flip flop or breaking of a promise?

The Goal is the Best Patient Care – This is not about moving hospitals, it's about providing the best care possible to patients. The question of how best to redevelop St. Paul's has been under discussion for decades. Patients, communities, governments and taxpayers want the solutions that make the most sense and use best practices, especially with changing health care technologies, population health

needs, changing demographics and evolving health-system priorities. That means looking at numerous options.

History of Previous Concept Plan – In 2010, then health minister Kevin Falcon requested Providence to develop a concept plan for upgrading St. Paul's at the current site. This work proceeded through a Ministry of Health project board and a final submission was made by Providence last year.

Ambulatory Building Focus – The concept plan proposed an ambulatory building as a first phase of redevelopment, some retrofitting of inpatient buildings, and some seismic upgrades, at the current location of the hospital.

Gaps in Previous Plan – We looked at this option comprehensively and it was extremely informative. But after reviewing this proposal – which had an estimated cost of \$850 million and which didn't optimally address key patient-care needs, such as single-rooms – it became clear this option had many gaps and would not be ideal.

History of Options – The completion of the concept plan meant that we now have done two detailed plans and analysis: 1) Renewal at Station Street, the planning for which was done about 8 years ago, and 2) Upgrades at current Burrard site.

Station Street Option Aligns with New Health Vision – With knowledge of the two options that have been looked at over the past 10 years, Providence, with the support of the Ministry of Health can now develop the option – Station Street – that puts us at the forefront of providing an approach that integrates acute and primary care and is the right solution for patients.

Same Solution Cannot Be Done at Current Burrard Site – The Station Street site provides an opportunity that is not available on St. Paul's current site on Burrard Street, which has limited site area and the requirement to maintain hospital operations during extensive redevelopment and construction.

13. How long has this new proposal been under development and why haven't you been consulting stakeholders before deciding on pursuing this option again?

Option Always Available – Which option is best for St. Paul's, including for a build at Station Street, has been an open and public point of discussion for years. For this latest proposal, the option to renew at Station Street once again started becoming apparent as we looked at how the last concept plan couldn't meet the patient needs that were required.

Old Plan Not Good Enough – This included looking at new system solutions, including how best to approach capital investments and new hospital builds. Through such interactions, numerous questions arose about the current concept plan for renewing St. Paul's at the current site – whether that was the most effective investment to make for patient care or not.

Opportunity for Consultation – Because it became very apparent that the solutions in the last Concept Plan were lacking, it was felt a consultation process on this plan would not be a prudent use of taxpayer resources. That plan is available if for reviewing if people want to read it (at our website). We will be doing

comprehensive public consultation and expect a robust discussion on all aspects, pros and cons of ideas about St. Paul's Hospital redevelopment.

14. Isn't the new project cost more than doing the renewal at the current site? How will Providence bring dollars to the table? Can you provide details? What "assets" does Providence have?

Government's \$ Investment – The cost to taxpayers (government's \$ commitment) remains the same as previously stated – \$500M. But the solution at Station Street is much better for patients and communities and is achievable because of the investment Providence Health Care can bring through its land assets and through its donor community and it can be done between 5 to 7 years, instead of 15 years or more.

The bottom line is that what we will build at the new site is a much bigger vision with a broader range of service than what would have been built at St. Paul's Hospital at Burrard Street site. In addition to a fully equipped state of the art acute care services, we will be expanding access to community care, with new mental health beds, residential care beds, 24/7 Primary Care, chronic disease management services, a birthing site with a goal of putting the patient first.

Business Plan Required – A detailed Business Plan will need to be done to finalize all aspects of the project; it will include more information on how Providence will contribute through asset leveraging, partnerships and donor/philanthropic initiatives. Providence has numerous land assets in Vancouver, including at Station Street, St. Paul's Hospital, Mount Saint Joseph Hospital, the old St. Vincent's Hospital site at 33rd and Heather, and others. What opportunities are available to use the lands will be determined through the Business Plan process.

15. What will be left behind at these sites and what will you do with the land?

Opportunities for Future – How the current St. Paul's Hospital land will be used after the new hospital and health centre are developed is still to be determined. There are numerous opportunities and options that could be looked at.

Consultation for Future Use of Lands – We will be looking at balancing what's best for the community and neighbourhoods, and which partners are interested in developing our available properties for which solution. The lands could be used for a mixture of commercial, business, housing, and other community, health or social services. We will engage with the communities and neighbourhoods impacted and look at their community development plans for the future and seek partners to see how best to use the lands for the long term. We will work with the City of Vancouver to develop appropriate and comprehensive community consultation plans regarding the lands.

16. How far away is Station Street from the current St. Paul's?

Distance/Driving Times – The Station Street site is 3 kms from the current St. Paul's location – an 8-minute drive by car (10 minutes in traffic). [Source: Google Maps]

Ideal Location – While still located in the heart of Vancouver, the Station Street site is an ideal location for improved accessibility for patients. It is at the nexus of major Vancouver transportation arteries and neighbourhoods, close to SkyTrain, railway/train, and Greyhound/bus stations.

Accessible – It is in a neighbourhood – East False Creek Flats – that has a robust City of Vancouver plan for future development and transformation, including improving transportation access and vehicle traffic by eliminating the Georgia Viaduct/overpass.

Previous Support for Option – Based on past stakeholder engagement, the neighbourhood is strongly supportive of a new hospital in the area. The same support existed from Downtown Eastside groups.

Closer to DTES/Area of Increasing Patient Need – The Station Street site is also closer to the Downtown Eastside, a neighbourhood from where more and more patients are presenting at St. Paul's emergency departments.

17. Moving St. Paul's means there's no major health care facility in the downtown core. In the event of an earthquake or major disaster, won't 90,000 residents of Vancouver's West End, downtown and other core areas be left vulnerable? Won't the Station Street site be underwater if there's an earthquake and/or a tsunami?

Need for System Response – A major disaster, such as a devastating earthquake, will require a provincial, if not national, response. One hospital on its own will not be able to cope. The 2011 Stanley Cup riots demonstrated St. Paul's Hospital was overwhelmed by the arrival of 100 patients to its doors, suffering from mostly minor injuries. A scenario of thousands arriving could not be manageable, especially if most of the hospital buildings – which are currently not to seismic code – will be damaged or destroyed.

Latest Seismic Solutions – The Station Street site and all the facilities can be designed with the latest seismic codes and earthquake-readiness standards in the world, integrated with the latest municipal, provincial and national emergency management response plans.

New Solution Means Improved Emergency Preparedness – A hospital and campus of care at Station Street will be better able to cope. With 18.5 acres of space currently available, it will have more room to stage large emergency response, triaging and crowd management activities, inside and outside of the hospital and campus of care facilities.

18. Isn't the Station Street site environmentally unsound, the soil polluted? How can you put a health care facility there?

Addressing All Environmental/Mitigation Requirements – There are strict environmental mitigation standards and codes that have to be met prior to any development. This project will ensure all such requirements are addressed.

19. Significant dollars to SPH over the years have come from donors and the government has invested millions in capital upgrades in both hospitals. Has this been for nothing?

The historic investments into the hospital – by the provincial government, by Providence and by the donor community – have contributed greatly to patient and resident care. They have helped the hospital and care staff achieve great outcomes.

The donor and philanthropic community share the same goals as health care providers: to ensure we provide patients, families and communities the best care that we can.

Building state-of-the-art health care facilities to replace St. Paul's builds on our strong commitment to exceptional patient care, research and teaching.

20. Will any of St. Paul's cardiac program, renal services, and teaching functions be transferred to other facilities in the region? Will the Core Hospital have a high-risk maternity care? Will the hospital and integrated health centre remain an Academic Health Sciences Centre?

The project planning will look at all the clinical programs at St. Paul's and how best to design their delivery to ensure the patients', the health region's and the province's care needs are met.

Our current planning assumption takes into account that all major tertiary and quaternary programs and services that St. Paul's has been known for nationally and globally will continue to be part of the new redevelopment. High-risk maternity care is expected to continue to be part of the core hospital. Also contemplated is a birthing centre (for normal/low-risk deliveries) as part of the adjoining integrated health centre.

21. When is a shovel going to be put in the ground? How long will it take to build the new hospital and integrated health centre?

A formal timeline for construction will be determined as part of the Business Plan process. Initial estimates are that a project of this scope could take anywhere from five to seven years to implement from approval of the Business Plan.

22. St. Paul's Hospital is a heritage building. Don't parts of it have to be preserved?

St. Paul's Hospital is listed on the Vancouver Heritage Register category "A" but is not a designated heritage building and is not currently protected by legal statute. Aspects of the Burrard Building, which was built in 1912, could qualify for City of Vancouver's heritage designation bylaws.

The heritage aspect of the Burrard Building is important to Providence Health Care and our history. Project planning will include taking into account the heritage preservation aspects in accordance with existing bylaws and community standards.

23. What is the Esperanza Society and why does it own the Station Street site?

At the time the Station Street site became available (at a cost of \$24.5 million) in 2004/05, Providence Health Care didn't have the ability to carry the debt. The Esperanza Society is a separate non-profit entity that was created in 2005 by

individuals interested in promoting the renewal of St. Paul's Hospital. The Society bought the land to hold for a possible future redevelopment of St. Paul's.

It was felt that since the acquisition of the land had a potential to be a temporary transaction – in case the Station Street site was not chosen for the redevelopment – then it was more prudent that a separate, non-profit Society continue to hold the land until a decision on St. Paul's was finalized.

The Society didn't have the ability to pay the annual property taxes (between \$700,000 to \$800,000 annually), so Providence provided the cash (in non-operating funds) to the Society for the first four years. After this, it became a challenge for Providence to provide the funds, and the provincial government stepped in to make the payments starting in 2008.

The land has been a prudent investment and its original property value has more than doubled. Taxpayers are protected from any losses.

24. Will this development be done as a P3? Isn't that moving our public health care system toward a private health care system? Haven't P3s been proven to be a bad deal for taxpayers?

The Business Plan process will determine what funding and building options are recommended. However, P3s have been proven to be effective in developing health care infrastructure in BC in recent years. Nearly a billion dollars of health-care capital investment in the lower mainland have resulted in three major projects built on time and on budget using a P3 model: a new 300-bed regional hospital and cancer centre opened in Abbotsford in 2008, the region's first outpatient care and surgery centre of excellence opened in Surrey in 2011, and a new critical care tower in Surrey opened in 2014.

25. What are the next steps?

Business Plan Development/Public Consultation – More details will be coming in the upcoming days and weeks. But, as with any major public sector project, comprehensive Business Plan development and stakeholder/community consultation processes will follow. The Business Plan is expected to take approximately a year, to a year-and-a-half, which will be followed by procurement. At the same time, the old hospital will continue to provide high-quality, uninterrupted care.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 4:05 PM
To: Michell, Jennifer HLTH:EX
Subject: RE: TB - Jan 19

Terrific thx

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 4:04 PM
To: Scheffel, Emile HLTH:EX
Subject: Re: TB - Jan 19

Yes I have sent this to Manjit to connect with TBS. Will keep posted.

Sent from my BlackBerry 10 smartphone on the Rogers network.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 4:02 PM
To: Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: TB - Jan 19

Jen, could you ask them about 3:30?

Thanks again...

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:58 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: TB - Jan 19

Thanks so much Emile

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:57 PM
To: Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: Re: TB - Jan 19

Sounds good — will leave this with Shaina to work out.

Thanks! E

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM
To: Michell, Jennifer HLTH:EX; Jukes, Shaina HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

He's tied up 2-3 pm, not including travel time.

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:55 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Emile,

If we can get on first on the agenda would that help? Is there a particular time he is available between 1-5 that we could work with TBS on?

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:44 PM
To: Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

FYI Jen and Andrea – Shaina is submitting a leave request from TB which is indeed now from 1 to 5.

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:37 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

Yup this is a problem.

Shaina Jukes

Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:36 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX

Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 4:03 PM
To: Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: TB - Jan 19

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Thanks again...

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Thanks! E

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 3:56 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: TB - Jan 19

So would he be seeking leave between 1:30-3:30?

Am thinking maybe we could see if we could be 1st up at 1 or up at 3:30/4?

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Manager, Corporate Services
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Scheffel, Emile HLTH:EX

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Sent: Tuesday, January 12, 2016 3:43 PM
To: Jukes, Shaina HLTH:EX; Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: TB - Jan 19

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Subject: RE: TB - Jan 19

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Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca

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Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:36 PM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: PAD - Coroners Act Implications
Attachments: 1044109 - IN Physician Assisted Dying Coroners Act Implications - 2015 Dec 21.doc

Importance: High

Minister,

Sorry for the late notice – staff have provided the attached (very brief) IN that you may want to take a look at for tomorrow's JAG/PSSG joint meeting.

It's on your iPad for tomorrow.

Thanks E

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Chiff # 1044109

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

TITLE: Physician Assisted Dying – *Coroners Act* implications

PURPOSE: To discuss the BC *Coroners Act*, as it pertains to implementing Physician Assisted Dying.

BACKGROUND:

- On February 6, 2015, the Supreme Court of Canada struck down the *Criminal Code* prohibitions against physician assisted dying (Assisted Dying) on the basis that they violate the *Canadian Charter of Rights and Freedoms*.
- The Supreme Court ruling was stayed until February 2016, giving the federal, provincial and territorial governments one year to enact legislation or policies to clarify the rules and safeguards around Assisted Dying, should they choose to do so.
- On November 30, 2015, the P/T Expert Advisory Group on Physician Assisted Dying (the Advisory Group) issued its final report (the Final Report – Appendix A) with non-binding advice for P/T Ministers of Health and Justice on implementing Assisted Dying.
- On December 3, 2015, the Attorney General of Canada filed a motion for a six-month extension of the Supreme Court's decision on Assisted Dying. Subject to approval, the new deadline for implementation would be August 6, 2016.
- The BC *Coroners Act* received assent on May 31, 2007.

DISCUSSION:

- The Advisory Group's Final Report includes four recommendations that directly relate to the *Coroners Act* and/or have potential implications for the BC Coroners Service:
 - **Recommendation 4:** All provinces and territories should ensure access to Assisted Dying, including both physician-administered and self-administered Assisted Dying.
 - **Recommendation 29:** Following the provision of Assisted Dying, physicians should file a report with a Review Committee to support the review of each individual case.
 - **Recommendation 39:** Provincial and territorial governments should establish [...] Review Committee systems to review all cases of Assisted Dying after the provision of the service to ensure compliance with relevant federal/provincial/territorial legislation and health professional regulatory standards, transparency and accountability.
 - **Recommendation 30:** Assisted Dying should be listed as the manner of death on medical certificates of death across all provinces and territories and the name of the medical condition that qualified the patient for Assisted Dying should be listed as the cause of death.

Coroners' Reviews of Self-Administered Deaths/Suicides

- Section 2 of Part 2 of the *Coroners Act* includes a requirement that anyone with information that a person has died as a result of self-inflicted illness or injury must immediately report the facts and circumstances to a Coroner or a peace officer.
- Based on legal advice, this requirement would apply to the Assisted Death of a person as a result of taking medication prescribed by a physician.
- On receiving such a report, either directly or from a peace officer, a Coroner would be required by Section 7 of the *Coroners Act* to investigate the death.
- The aforementioned requirements to report and investigate could not be avoided or overwritten by means of policy.

Case Review

- The proposed Review Committee for Assisted Dying cases, as described in recommendations 29 and 39 from the Final Report (above), is primarily intended to ensure clinical criteria for Assisted Dying fall within reasonable limits and are not subject to abuse.
- In fulfilling this medical oversight and accountability role, the Review Committee would likely be performing some activities that overlap with BC Coroners Service duties already enshrined in legislation.
- To reduce duplication of effort and ensure role clarity, any Review Committee for Assisted Dying cases in BC should be developed in consultation with the BC Coroners Service.

ADVICE:

- The Chief Coroner should be involved as soon as possible in implementation planning for Assisted Dying to ensure all implications for the Coroners Service of the Supreme Court's decision are fully addressed.

Program ADM/Division:	Doug Hughes, ADM, Health Services Policy Division
Program Contact (for content):	Brian Sagar, Director of Patient Safety, 250-952-2753
Date:	December 22, 2015

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:36 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: TB - Jan 19

Hi there,

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Could you please confirm?

Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:24 PM
To: Jukes, Shaina HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: s.13
s.13

Ok can you please forward him the original email with a reminder?

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:24 PM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: s.13
s.13

Yes it is still on his iPad under DBN's for decision.

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:18 PM
To: Jukes, Shaina HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: s.13
s.13 }

Did it already go up to him?

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:17 PM
To: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: FW: s.13
s.13

The attached DBN is on MTL's iPad for approval, it is one staff feel is time sensitive. Derek and Emile if either of you get a moment can you please follow up with MTL on it.

Thank you,
Shaina

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Docs Processing HLTH:EX
Sent: Wednesday, December 16, 2015 9:25 AM
To: HLTH Ministers Office
Cc: Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: s.13
s.13

Hi All:

The attached briefing document and power point presentation have been prepared by MBPSD for Minister's decision on PharmaCare coverage of the cholinesterase inhibitor drugs to complete the Alzheimer's Drug Therapy Initiative. Barbara Walman and Manjit Sidhu, ADMs and by Lynn Stevenson, Associate DM have approved. We understand that a briefing has been requested and Andrea will be in touch with your office to arrange.

We would appreciate receiving a copy of the signed document once Minister has approved.

Thanks so much,

Kathy Simonson
Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 3:22 PM
To: Jukes, Shaina HLTH:EX
Subject: RE: FPT sidebar re e-cigarettes

We're going to try and do it right after the p/t press conference so IGR will work it into the schedule

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 3:21 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: FPT sidebar re e-cigarettes

Did anything ever come of this?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Scheffel, Emile HLTH:EX
Sent: Friday, January 8, 2016 2:22 PM
To: Marr, Ann HLTH:EX; Poillievre, Tricia HLTH:EX
Cc: Merrifield, Katy PREM:EX; Jukes, Shaina HLTH:EX
Subject: FPT sidebar re e-cigarettes

This has come in now – do we figure we can accommodate?

Thanks E

From: Lake, Terry HLTH:EX
Sent: Friday, January 8, 2016 2:07 PM
To: Scheffel, Emile HLTH:EX
Subject: Fwd: This message is being sent on behalf of Ontario Associate Minister of Health Dipika Damerla

Will this work in the schedule?

Terry Lake DVM
Minister of Health

Begin forwarded message:

From: "Afrah, Kadijo (MOHLTC)" <Kadijo.Afrah@ontario.ca>
Date: January 8, 2016 at 2:03:13 PM PST
To: "Terry.Lake@gov.bc.ca" <Terry.Lake@gov.bc.ca>
Subject: This message is being sent on behalf of Ontario Associate Minister of Health Dipika Damerla

Dear Minister,

I look forward to seeing you in Vancouver in a few weeks. The

suggest we gather at about 3:30 on Wednesday the 20th for a half hour or so. If that time doesn't work for you perhaps you could identify another opportunity.

Please feel free to reply to Kadijo, and we will determine an appropriate location closer to the meeting.

Kind Regards,

Dipika Damela
Associate Minister of Health and Long Term Care
(Long Term Care and Wellness)

Kadijo Afrah
Scheduler and Office Manager
Office of the Hon Dipika Damerla
Associate Minister of Health and Long Term Care (Long Term Care and Wellness)

11th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
Tel: 416-212-3180
Fax: 416 326 1571

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Subject: FW: s.13
s.13

The attached DBN is on MTL's iPad for approval, it is one staff feel is time sensitive. Derek and Emile if either of you get a moment can you please follow up with MTL on it.

Thank you,
Shaina

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Andrachuk, Andrea HLTH:EX
Sent: Friday, January 8, 2016 9:59 AM
To: Jukes, Shaina HLTH:EX
Subject: FW: s.13
s.13

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | **C:** 250.217.3655 | **email:** andrea.andrachuk@gov.bc.ca

From: Docs Processing HLTH:EX
Sent: Wednesday, December 16, 2015 9:25 AM
To: HLTH Ministers Office
Cc: Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: s.13
s.13

Hi All:

Kathy Simonson

Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health

5-3 1515 Blanshard St, Victoria BC V8W 3C8

Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 2:33 PM
To: Docs Processing HLTH:EX
Cc: HLTH Ministers Office; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: RE: 1044109 - ProgGen IBN for MTL - Physician Assisted Dying Coroners Act Implications

Ok thanks

From: Docs Processing HLTH:EX
Sent: Tuesday, January 12, 2016 2:19 PM
To: Scheffel, Emile HLTH:EX
Cc: HLTH Ministers Office; Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: 1044109 - ProgGen IBN for MTL - Physician Assisted Dying Coroners Act Implications
Importance: High

Hi Emile:

Program staff advised this material was not initially prepared for the discussion tomorrow, but it would likely be beneficial for the Minister to review prior to.

Thanks so much,

Kathy Simonson
Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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From: Scheffel, Emile HLTH:EX
Sent: Monday, January 11, 2016 8:00 AM
To: Docs Processing HLTH:EX; HLTH Ministers Office
Cc: Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: RE: 1044109 - ProgGen IBN for MTL - Physician Assisted Dying Coroners Act Implications

Was this intended for the JAG/PSSG/HLTH meeting on Wednesday?

Thanks E

From: Docs Processing HLTH:EX
Sent: Friday, January 8, 2016 2:22 PM
To: HLTH Ministers Office
Cc: Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: 1044109 - ProgGen IBN for MTL - Physician Assisted Dying Coroners Act Implications

Thanks so much,

Kathy Simonson

Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health

5-3 1515 Blanshard St. Victoria BC V8W 3C8

Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 2:12 PM
To: Lowe, Tracey HLTH:EX; Andrachuk, Andrea HLTH:EX; Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: RE: PCC mtg tomorrow

Just looking back at a previous email he sent MTL – looks like he is aware.

Thx E

From: Lowe, Tracey HLTH:EX
Sent: Tuesday, January 12, 2016 2:11 PM
To: Scheffel, Emile HLTH:EX; Andrachuk, Andrea HLTH:EX; Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: RE: PCC mtg tomorrow

Thanks Emile, We will make Stephen aware of the topic. He has been invited to attend via telepresence by the Premier's office but we were not aware of the topic.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 2:04 PM
To: Andrachuk, Andrea HLTH:EX; Michell, Jennifer HLTH:EX; Lowe, Tracey HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: PCC mtg tomorrow

I'm advised it's on nurses bargaining – could you please make sure Steve is aware.

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 1:56 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: PCC mtg tomorrow

Hi Emile,

There is nothing in the DM's calendar and we've not been looped in. I will leave to Shaina to respond if there was any verbal indication.

Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 1:53 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: PCC mtg tomorrow

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 2:04 PM
To: Andrachuk, Andrea HLTH:EX; Michell, Jennifer HLTH:EX; Lowe, Tracey HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: PCC mtg tomorrow

I'm advised it's on nurses bargaining – could you please make sure Steve is aware.

Thanks E

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 1:56 PM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: RE: PCC mtg tomorrow

Hi Emile,

There is nothing in the DM's calendar and we've not been looped in. I will leave to Shaina to respond if there was any verbal indication.

Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 1:53 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: PCC mtg tomorrow

I'm sorry to ask so late – do we have any indication of agenda for PCC/MTL meeting tomorrow?

Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 1:53 PM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX
Cc: Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: PCC mtg tomorrow

I'm sorry to ask so late -- do we have any indication of agenda for PCC/MTL meeting tomorrow?

Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 1:20 PM
To: 'Thornthwaite, Jane'
Cc: Robertson, Derek HLTH:EX
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hi Jane,

I don't know the exact answer to that yet – though there will be a communication out to the public following the meetings.

We'll keep you posted.

Thanks! E

From: Thornthwaite, Jane [<mailto:J.Thornthwaite@leg.bc.ca>]
Sent: Tuesday, January 12, 2016 12:54 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hi Emile, is MTL going to give us an update on this meeting?

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 12, 2016 10:24 AM
To: Thornthwaite, Jane <J.Thornthwaite@leg.bc.ca>; Lake, Terry HLTH:EX <Terry.Lake@gov.bc.ca>
Cc: Dhanowa, Damon HLTH:EX <Damon.Dhanowa@gov.bc.ca>
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hi Jane,

Thought I would give you a quick response as Minister Lake is tied up at an event this morning.

The federal/provincial/territorial component of the meeting will include a pretty heavy focus on the most pressing challenges facing health care systems, as well as on community care – two areas in which we expect mental health will be one of the top issues.

As you know, mental health and particularly CYMH are areas of high priority for us. Looking forward to sharing more info on these conversations following next week's meetings.

Best,

E

From: Thornthwaite, Jane [<mailto:J.Thornthwaite@leg.bc.ca>]
Sent: Tuesday, January 12, 2016 10:16 AM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: FW: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hello Minister. Happy New year!

Jane

From: Government of British Columbia [mailto:GCPE.News@gov.bc.ca]
Sent: January 12, 2016 8:54 AM
To: GCPEMINIS@gov.bc.ca
Subject: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Jan. 12, 2016

MEDIA ADVISORY - Federal, provincial and territorial Health Ministers

VANCOUVER - The Honourable Jane Philpott, Canada's Minister of Health, and the Honourable Terry Lake, British Columbia's Minister of Health, will co-chair a meeting of federal, provincial and territorial Health Ministers in Vancouver, B.C., January 20 and 21.

Please note all details are subject to change. All times are local Pacific time. Media teleconference details to be provided at a later date.

DATES:

On January 20, Minister Lake will host provincial and territorial Health Ministers, while both Ministers Philpott and Lake will co-chair the meeting on January 21.

TIMES:

Wednesday, January 20, 2016 - Provincial-territorial Health Ministers' meeting

7:30 a.m. - Media registration opens

8:30 a.m. - Photo opportunity with Ministers prior to start of meeting

3:15 p.m. - News conference with provincial and territorial Health Ministers

Thursday, January 21, 2016 - Federal-provincial-territorial Health Ministers' meeting

7:00 a.m. - Media registration opens

8:00 a.m. - Photo opportunity with Ministers prior to start of meeting

2:20 p.m. - News conference with federal, provincial and territorial Health Ministers

LOCATION:

All media events will be held at the Fairmont Hotel Vancouver
900 West Georgia Street
Vancouver, B.C.

Media who wish to attend must register upon arrival and obtain accreditation by presenting press identification at the Saturna Island Room.

CONTACTS:

Media Relations
B.C. Ministry of Health
250 952-1887

Media Relations

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 12:53 PM
To: Morris, Kirsty L LASS:EX; Robertson, Derek HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: Mtg with MTL & Phoenix Centre

Thanks! Derek and Shaina, can I leave staff and materials to you?

Thanks E

From: Morris, Kirsty L [mailto:Kirsty.Morris@leg.bc.ca]
Sent: Tuesday, January 12, 2016 12:52 PM
To: Scheffel, Emile HLTH:EX; Robertson, Derek HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: RE: Mtg with MTL & Phoenix Centre

Meeting has been arranged for **Thursday February 4th at 10am** - I have put it in the calendar

Over to you.....

Thank you!

Kirsty

Kirsty L Morris | Constituency Assistant

Terry Lake, MLA Kamloops - North Thompson
Minister of Health

Email: kirsty.morris@leg.bc.ca
Phone #: [250-554-5413](tel:250-554-5413) Fax #: [250-554-5417](tel:250-554-5417)
Toll Free #: [1-888-299-0805](tel:1-888-299-0805)
Website: www.terrylakemla.bc.ca



Be Green! Read from the screen

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January 11, 2016 1:51 PM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>; Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Cc: Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca>
Subject: RE: Mtg with MTL & Phoenix Centre

Great thx!

From: Morris, Kirsty L [mailto:Kirsty.Morris@leg.bc.ca]
Sent: Monday, January 11, 2016 12:28 PM

Kirsty L Morris | Constituency Assistant

Terry Lake, MLA Kamloops - North Thompson
Minister of Health

Email: kirsty.morris@leg.bc.ca
Phone #: [250-554-5413](tel:250-554-5413) Fax #: [250-554-5417](tel:250-554-5417)
Toll Free #: [1-888-299-0805](tel:1-888-299-0805)
Website: www.terrylakemla.bc.ca



Be Green! Read from the screen

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 11, 2016 11:12 AM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>; Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Cc: Jukes, Shaina HLTH:EX <Shaina.Jukes@gov.bc.ca>
Subject: RE: Mtg with MTL & Phoenix Centre

Could we leave scheduling to you and provide materials/staff from our end?

From: Morris, Kirsty L [<mailto:Kirsty.Morris@leg.bc.ca>]
Sent: Monday, January 11, 2016 11:11 AM
To: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Cc: Jukes, Shaina HLTH:EX
Subject: Mtg with MTL & Phoenix Centre

Good Morning All!

The following meeting request has been received in the CO from the ED of the Phoenix Centre which is located here in Kamloops.

MTL has reviewed the request this morning and agreed to this meeting.

As this is Health, let me know if you wish to take over arrangements for this meeting.

MTL has requested BN and staff for this meeting and he also wants Interior Health informing that he will be meeting with them in advance.

Let me know how you would like to proceed with the arrangements for this one.

Thanks Kirsty

Kirsty L Morris | Constituency Assistant

Terry Lake, MLA Kamloops - North Thompson
Minister of Health

Email: kirsty.morris@leg.bc.ca
Phone #: [250-554-5413](tel:250-554-5413) Fax #: [250-554-5417](tel:250-554-5417)
Toll Free #: [1-888-299-0805](tel:1-888-299-0805)

From: Sian Lewis (<mailto:sian.lewis@phoenixcentre.org>)
Sent: January 8, 2016 2:57 PM
To: Morris, Kirsty L <Kirsty.Morris@leg.bc.ca>
Cc: Shelly Bonnah <SBonnah@interiorcommunityservices.bc.ca>
Subject: Requested meeting with Terry Lake

Hello Kirsty,

Thank you for your time this afternoon. Below is the information requested.

I request a meeting with Hon. Dr. Terry Lake to discuss the *Supportive Transitional Living in Recovery* (STLR) pilot project. This program is specific to those who have recently completed the withdrawal management (detox) component of addiction treatment and require a supportive *living-in-recovery* community to maintain abstinence and engage fully in their ongoing treatment plan.

<http://www.phoenixcentre.org/supportive-transitional-living>

This project was initiated in the spring of 2013 with funding from United Way, Royal Inland Hospital Foundation and Stollery Foundation. This past fiscal, the program also received one-time funding from the Homelessness Partnering Strategy via the City of Kamloops. We are grateful to our funders for their two-year commitment and are now looking for permanent funding to ensure this program is sustained well into the future. We have approached our local health authority to request support, but currently there is no ability for them to commit financially to this program.

I understand the development of 'an additional 500 addiction spaces' (Ministry of Health, 2014/15 – 2016/17, Service Plan) falls within your portfolio; and I am hopeful this initiative aligns well with my objective to secure permanent funding for this critical health-focused transitional housing program. Phoenix Centre has been part of the regional review of the substance use continuum of care. We know sanctioned community-based supportive-living-in-recovery programs are cost efficient and effective.

- Approximate annual program cost is \$100,000.00 to support 11 clients in early recovery
- Program has been at full capacity since opening November 2013
- Clients are in a tenancy agreement; therefore pay their own living expenses (rent, food, etc.)
- We have tracked as much as a 83% decrease in these clients accessing emergency department, RCMP and/or ambulance services (specific to their substance use)
- STLR is part of the youth housing inventory managed by the A Way Home Committee and supported by the Wrap Force
- Allowable length of stay is not predetermined, but client stays range from 3 months to 12 months, with clients 'graduating' to permanent independent housing upon discharge
- Client successes include reaching sobriety milestones, securing employment, volunteering in the community, and/or entering into an educational program
- Our pre and post client surveys consistently reflect improvements in multiple life domains (physical & mental health, social & family relationships, education, employment, etc.)

Shelly Bonnah, with Interior Community Services will also attend this meeting to speak to the importance of STLR as it relates to youth housing. We look forward to meeting with Hon. Dr. Terry Lake. Please let us know when this can be arranged.

Warm regards,



Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 12:41 PM
To: Brown, Stephen R HLTH:EX; Hughes, Doug J HLTH:EX; Plank, Sarah GCPE:EX
Cc: Stearn, Anne HLTH:EX
Subject: BC Cancer

Just noting for you Dr. Moore's comments in today's avail.

E
--

Reporter: Dr Moore, can you just talk about your first few months on the job and which changes, if any, you've made to the agency and any solutions you've found for some of the problems that it was facing?

Moore: Wow. Okay. In all honesty, I have been here just four months now. I have spent a lot of time travelling around the province meeting people working in the different regional cancer centres, in the regional health authorities.

I guess the one thing I would say is this is a very complex system, and there's a lot of moving parts. What we have committed to is a plan to reorganize the way the agency functions to kind of position us for the future, and the one thing I would say, and it maybe leads on to the comment about palliative care, is that the vision that we're taking is that the cancer.... We have to look at the entire cancer journey. It's not just about the treatment which you've heard about today. We have to make sure that patients in British Columbia have appropriate high-level services through screening, diagnosis, treatment, then supportive care and end-of-life care.

That's the approach that the agency is taking. We're in the middle of actually writing a policy paper for the government which lays out this plan, and then we're going to reorganize the agency to some degree to allow it to position us to deliver on that in the future.

I would say it's been a really exciting time, and the most energizing thing is really the commitment of the people who work in the agency and deliver the services and the passion that they have for the work that they do, which I think translates into the fact that we have such good outcomes and high patient satisfaction scores. It's been a great four months.

Reporter: [Inaudible].

Moore: We're working on this now. We would plan to announce a reorganization of how the agency is structured probably at the end of February.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 12:10 PM
To: Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Go for it, thanks!

Let's just emphasize MTL has a prior commitment.

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 12:09 PM
To: Scheffel, Emile HLTH:EX; Jukes, Shaina HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

I think it is certainly interesting. Perhaps I should call this person and ensure they are amenable to hosting a member before making the offer?

It's Sam's riding and normally he doesn't attend these things unless we insist (I will say this is different to what we usually offer).

Looks like a cool little luncheon though. Let me know if you'd like me to reach out. I guess another member option would be Dr. Stilwell, might be more appropriate considering it is in support of the BC Women's Hospital.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:59 AM
To: Jukes, Shaina HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Thx – Damon what do you think

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 11:58 AM
To: Scheffel, Emile HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: FW: Illuminations Luncheon - Jan 26, 2016 - INVITATION

MTL has CCST this day so I was going to send regrets, do we want to offer an MLA or anything?

Shaina Jukes

*Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca*

From: Robin Dhir [<mailto:rdhir@fasken.com>]
Sent: Tuesday, January 12, 2016 11:42 AM
To: Merrifield, Katy PREM:EX; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Robin

From: Merrifield, Katy HLTH:EX [<mailto:Katy.Merrifield@gov.bc.ca>]
Sent: January-07-16 3:39 PM
To: Robin Dhir; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Robin,

Same to you! I've included the Minister's AC Shaina who will get back to you on the Minister's availability.

Cheers,

Katy Merrifield
Chief of Staff to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547
Katy.Merrifield@gov.bc.ca

From: Robin Dhir [<mailto:rdhir@fasken.com>]
Sent: Thursday, January 7, 2016 3:37 PM
To: Merrifield, Katy HLTH:EX
Subject: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Katy,

Happy New Year!

I wanted to reach out and share the below invite for Minister Lake.

I would like to invite him to be my (Faskens) guest at this luncheon. Perhaps, he has already been invited by the organizers, but if not, it would be my pleasure to host him.

We are the Presenting Sponsor and as such have the prime table in the room in front of the stage. We would arrange for him to speak as well.

Please let me know at your earliest convenience if this will work with his schedule.

Regards,

Robin Dhir | Strategic Advisor

T. +1 604 631 4953 | C. +1 604 786 0429 | F. +1 604 631 3232
rdhir@fasken.com | www.fasken.com

Fasken Martineau DuMoulin LLP
2900 - 550 Burrard Street, Vancouver, British Columbia, V6C 0A3

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YOU ARE INVITED TO THE ILLUMINATIONS FUNDRAISING
LUNCHEON IN SUPPORT OF BC WOMEN'S HOSPITAL.

Please join us and our special guest speaker Deepa Mehta
for an engaging + inspiring afternoon.

PRESENTED BY
FASKEN MARTINEAU

ILLUMINATIONS

FUNDRAISING LUNCHEON



TUESDAY, JANUARY 26, 2016 – 12:00 PM – 2:00 PM*
FOUR SEASONS HOTEL
791 WEST GEORGIA, VANCOUVER

*Ballroom doors open at 11:30 am. Program starts at 12:00 pm.



KEYNOTE SPEAKER: DEEPA MEHTA
OSCAR-NOMINATED FILMMAKER

Deepa Mehta is an Oscar-nominated (*Water*), transnational filmmaker whose work is celebrated on an international scale. Her award-winning films have played every major film festival, receiving numerous awards and many remain audience favourites.

Deepa's work challenges traditions and stereotypes and is always daring, fearless and provocative. In 2013, Deepa was appointed an officer of The Order of Canada for her groundbreaking contribution to film.

We are honoured that she will be joining us.

Illuminations is an annual fundraising event organized by BC Women's Hospital + Health Centre Foundation. This high-profile event consistently sells out and attracts over 400 representatives from business, industry and private sectors of Vancouver.



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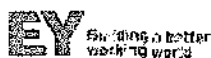


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4500 OAK STREET, ROOM D310, VANCOUVER, BC V6H 3N1

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 12:01 PM
To: Holme, Matt TRAN:EX
Cc: Dhanowa, Damon HLTH:EX; Robertson, Derek HLTH:EX
Subject: FW: Kanaka Creek Lodge residents needing assistance

Matt, as discussed.

Thanks E

From: Dalton.MLA, Marc [<mailto:Marc.Dalton.MLA@leg.bc.ca>]
Sent: Tuesday, January 12, 2016 11:15 AM
To: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: Kanaka Creek Lodge residents needing assistance

Hi, Damon and Derek

Cheryl Ennis, the Executive Assistant for Mayor Nicole Read in Maple Ridge called just now. On Saturday evening the Kanaka Creek Lodge was destroyed by fire. The 10 residents, all elderly men requiring daily support have been staying at the Quality Inn where their care aids and meals and medication are all be arranged by the Lodges staff.

However, tomorrow morning, the 72 hours of emergency financial support for the men expires and they will all be out on the street. My first thought when Cheryl said this was that it sure won't look good in the media tomorrow.

Mrs. Ennis, from City Hall, says that none of the men have family who can be of temporary support. She wanted to speak to Marc, but since he is away, I said I would contact you to see how we can go about providing these gentlemen extended support until they can be found new living arrangements.

If this information is not going to be enough for you to do something, could you let me know what I can do to help you help them.

I look forward to your response.

Kind regards,

Laurie Geschke
Constituency Assistant
for

Marc Dalton, MLA, Maple Ridge – Mission

(604) 476-4530 or 1.877.899.3215

Please note that I am in the office on Tuesdays, Wednesdays and Fridays.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:59 AM
To: Poilievre, Tricia HLTH:EX
Subject: RE: FN videos for FPT Reception

Perfect thx

From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 11:59 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: FN videos for FPT Reception

Great – that’s what I was thinking as well. We’ll run the first by him on Thurs, and not worry about the second.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:58 AM
To: Poilievre, Tricia HLTH:EX
Subject: RE: FN videos for FPT Reception

Thanks! First one for sure, but let’s please run by MTL as well. I don’t think the 2nd would work very well in this context.

From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 11:55 AM
To: Scheffel, Emile HLTH:EX
Cc: Poilievre, Tricia HLTH:EX
Subject: FN videos for FPT Reception

Hi Emile,

Not sure if you’ve seen these, as it’s been a while since we last discussed them with Katy. In our first HMM briefing with MTL back in the fall, we talked about including two brief video presentations on BC’s work with First Nations, for the FPT reception on Jan 20.

The two options staff here have recommended are:

BC FNHA Premier’s awards video (2014):
<https://www.youtube.com/watch?v=1lhqkgMwIkQ>

BC FN Leaders/Cabinet Gathering (2015):
<https://www.youtube.com/watch?v=5hlxtKBRvEA&feature=youtu.be>

We have time on the reception agenda to show both or just one of the above videos, or can easily remove them if MTL decides against it. I’m wondering if you have any feedback or preferences between them? We can show them to MTL on Thursday as well.

Thanks!

Tricia Poilievre
A/Director | Intergovernmental Relations | Ministry of Health, BC
Office: 250 952-1304 | Cell: 250 415-2639 | tricia.poilievre@gov.bc.ca

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:59 AM
To: Jukes, Shaina HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Thx – Damon what do you think

From: Jukes, Shaina HLTH:EX
Sent: Tuesday, January 12, 2016 11:58 AM
To: Scheffel, Emile HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: FW: Illuminations Luncheon - Jan 26, 2016 - INVITATION

MTL has CCST this day so I was going to send regrets, do we want to offer an MLA or anything?

Shaina Jukes

Administrative Coordinator to the Honourable Terry Lake
Minister of Health | PO Box 9050 Stn Prov Govt Victoria, BC V8W 9E2
Phone: 250-953-3547 | Fax: 250-356-9587 | Hlth.Health@gov.bc.ca

From: Robin Dhir [<mailto:rdhir@fasken.com>]
Sent: Tuesday, January 12, 2016 11:42 AM
To: Merrifield, Katy PREM:EX; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Shaina,

Do you have any updates for me?

Thx,

Robin

From: Merrifield, Katy HLTH:EX [<mailto:Katy.Merrifield@gov.bc.ca>]
Sent: January-07-16 3:39 PM
To: Robin Dhir; Jukes, Shaina HLTH:EX
Cc: Scheffel, Emile HLTH:EX
Subject: RE: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Robin,

Same to you! I've included the Minister's AC Shaina who will get back to you on the Minister's availability.

Cheers,

Katy Merrifield

To: Merrifield, Katy HLTH:EX
Subject: Illuminations Luncheon - Jan 26, 2016 - INVITATION

Hi Katy,

Happy New Year!

I wanted to reach out and share the below invite for Minister Lake.

I would like to invite him to be my (Faskens) guest at this luncheon. Perhaps, he has already been invited by the organizers, but if not, it would be my pleasure to host him.

We are the Presenting Sponsor and as such have the prime table in the room in front of the stage. We would arrange for him to speak as well.

Please let me know at your earliest convenience if this will work with his schedule.

Regards,

Robin Dhir | Strategic Advisor

T. +1 604 631 4953 | C. +1 604 786 0429 | F. +1 604 631 3232
rdhir@fasken.com | www.fasken.com

Fasken Martineau DuMoulin LLP
2900 - 650 Burrard Street, Vancouver, British Columbia, V6C 0A3

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MARTINEAU** 

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CHICAGO LONDON SUDBURY



illuminate.



LUNCHEON IN SUPPORT OF BC WOMEN'S HOSPITAL.

Please join us and our special guest speaker Deepa Mehta
for an engaging + inspiring afternoon.

PRESENTED BY
FASKEN MARTINEAU

ILLUMINATIONS

FUNDRAISING LUNCHEON



TUESDAY, JANUARY 26, 2016 – 12:00 PM – 2:00 PM*
FOUR SEASONS HOTEL
791 WEST GEORGIA, VANCOUVER

*Ballroom doors open at 11:30 am. Program starts at 12:00 pm.



Deepa Mehta is an Oscar-nominated (*Water*), transnational filmmaker whose work is celebrated on an international scale. Her award-winning films have played every major film festival, receiving numerous awards and many remain audience favourites.

Deepa's work challenges traditions and stereotypes and is always daring, fearless and provocative. In 2013, Deepa was appointed an officer of The Order of Canada for her groundbreaking contribution to film.

We are honoured that she will be joining us.

Illuminations is an annual fundraising event organized by BC Women's Hospital + Health Centre Foundation. This high-profile event consistently sells out and attracts over 400 representatives from business, industry and private sectors of Vancouver.

Illuminations supports the highest priority needs at BC Women's Hospital specifically related to women's healthcare. The funds from this luncheon will directly improve hospital programs, research, equipment and facilities to benefit the health and well-being of women locally and across our entire province.



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HOSPITAL +
HEALTH CENTRE
FOUNDATION**



BC WOMEN'S HOSPITAL + HEALTH CENTRE FOUNDATION
4500 OAK STREET, ROOM D310, VANCOUVER, BC V6H 3N1

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:58 AM
To: Poilievre, Tricia HLTH:EX
Subject: RE: FN videos for FPT Reception

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From: Poilievre, Tricia HLTH:EX
Sent: Tuesday, January 12, 2016 11:55 AM
To: Scheffel, Emile HLTH:EX
Cc: Poilievre, Tricia HLTH:EX
Subject: FN videos for FPT Reception

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We have time on the reception agenda to show both or just one of the above videos, or can easily remove them if MTL decides against it. I'm wondering if you have any feedback or preferences between them? We can show them to MTL on Thursday as well.

Thanks!

Tricia Poilievre
A/Director | Intergovernmental Relations | Ministry of Health, BC
Office: 250 952-1304 | Cell: 250 415-2639 | tricia.poilievre@gov.bc.ca

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:47 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX; Jukes, Shaina HLTH:EX; McCormick, Erika HLTH:EX
Subject: As discussed - Hospice Funding
Attachments: 1042945 - Funding to Support the Commitment to Double Hospice Spaces.docx

Minister,

Please see attached BN regarding Centre for Palliative Care. It's on your iPad under Approval > BNs for Decision.

Please let us know if you would like a briefing. Comms advises we could announce in February.

Thanks E

Page 1027 to/à Page 1028

Withheld pursuant to/removed as

s.13

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:13 AM
To: Dhanowa, Damon HLTH:EX; Thistle-Walker, Carlene GCPE:EX; Plank, Sarah GCPE:EX
Subject: RE: Quote Approval - Post-secondary students learn about a healthier drinking culture

Any reason why we couldn't do an event on this during session? Quite a bit of money...

Thanks E

From: Dhanowa, Damon HLTH:EX
Sent: Tuesday, January 12, 2016 10:34 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Scheffel, Emile HLTH:EX
Subject: Quote Approval - Post-secondary students learn about a healthier drinking culture

Good morning Minister – This NR is for release tomorrow afternoon after caucus releases go in the am. Thanks :D
2508847656

"As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning," said Lake. "Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person's life can help set them on the right track."

Post-secondary students learn about a healthier drinking culture

VICTORIA – Students at B.C. public post-secondary institutions will have access to additional supports to address substance use thanks to a \$400,000 investment for a project co-led by the Centre for Addictions Research of BC and the Canadian Mental Health Association BC Division, Health Minister Terry Lake announced today.

According to the 2013 National College Health Assessment Canadian survey, 26% of post-secondary students reported that the last time they socialized, they had seven or more drinks and 39% of students who drank alcohol in the last year said they later regretted something they did when drinking.

"As a parent I know it can be tough to talk to young people about responsible alcohol use, but the statistics are concerning," said Lake. "Excessive use of alcohol can lead to future challenges with addiction and helping to shift the culture towards moderate use at this pivotal point in a young person's life can help set them on the right track."

Changing the Culture of Substance Use is a project currently being implemented at 11 public post-secondary institutions throughout British Columbia. Changing the culture of alcohol and substance use is a long-term process that requires engagement from several levels of society, including communities, organizations, campus administration and individuals.

"Post-secondary students need to make informed choices on the use of alcohol," said Advanced Education Minister Andrew Wilkinson. "Facilitating a conversation on the use of alcohol is a good way to ensure that students have the full facts."

Project researchers are working with public post-secondary institutions to create a wider range of resources and strategies, which will engage key groups such as student leaders, students in residence and those in their first year.

"The Centre for Addictions Research of BC at the University of Victoria is pleased to continue its partnership with the Ministry of Health to ensure available evidence is utilized in real-world applications that improve the health of British Columbians," said Dan Reist, an assistant director at the centre. "In particular, the investment in changing the culture of substance use on post-secondary campuses currently supports locally developed, centrally supported projects at 11

"As someone who is going on their fourth year living in this residence, I have noticed a big change in how people drink and party in residence," said Hailee-Jean Lindgren, a student at Thompson Rivers University in Kamloops. "In my first year, there were stories of residence advisors needing to stay up all hours because parties kept being moved throughout the night. In my third year, when Drink with Class was first introduced, it turned around so that residents were willingly telling resident assistants about parties and asking for help in keeping those parties under control."

Campus-community partnerships are also being developed to help promote healthier relationships with alcohol among students. Recognizing that campuses exist within the context of a larger community, the partnerships will work with partners such as bars, pubs and transportation systems.

"The Canadian Mental Health Association BC Division appreciates the continued investments in student mental health and well-being by the Ministry of Health," said Bev Gutray, CEO at CMHA BC. "The Changing the Culture of Substance Use project is an integral part of our work promoting student mental health across British Columbia, through Healthy Minds, Healthy Campuses. With continued government investment, and in partnership with CARBC, we have built a strong and active network of BC campuses focused on ensuring the conditions are in place to increase participation in, and completion of, post-secondary education for all students."

This investment aligns with the provincial government's 10-year mental-health and substance use plan, Healthy Minds, Healthy People, which focuses on prevention, early intervention, treatment and sustainability of mental health and substance use supports. The announcement meets a commitment within the plan to provide more substance use initiatives across the province.

The Province also offers Alcohol Sense, a comprehensive suite of online resources aimed at providing parents with tools to guide and educate their children to make healthy decisions about alcohol through critical thinking and conversation.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:09 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: e-Prescribing update

Minister,

If you're amenable, staff can give you a quick update on e-Prescribing right after your 2:15 briefing on BC Clinical & Support Services – as Sabine will be with you and Deb will be on the phone.

If time runs out, or if you want more detail, we can schedule some time separately.

Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:07 AM
To: Andrachuk, Andrea HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: RE: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

Sorry to be a pain...the note doesn't answer "how many planned by end of 2016", though it looks like that may be hard to pin down.

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 11:02 AM
To: Scheffel, Emile HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: RE: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

I'll forward to staff.
Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 11:01 AM
To: Andrachuk, Andrea HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: RE: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

Definitely helpful thanks! Just wondering if we can get an answer to bullet 2:

- Starting # of beds
- How many added to date
- How many planned by end of 2016

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 10:58 AM
To: Scheffel, Emile HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

Hi Emile,
Would the attached progress report on Hospice spaces do for your update request?
Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

Hi All:

Attached is the above noted Progress Report to Treasury Board, approved by Manjit Sidhu, ADM and Lynn Stevenson, Associate DM. This report is for Minister's signature and will not be scheduled for Treasury Board. Please connect with Andrea if a briefing is required.

We would appreciate receiving a copy of the signed document once Minister has approved.

Thanks so much,

Kathy Simonson

Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998

kathy.simonson@gov.bc.ca

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Scheffel, Emile HLTH:EX

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Sent: Tuesday, January 12, 2016 11:01 AM
To: Andrachuk, Andrea HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
Subject: RE: Doubling of Hospice Spaces: Progress Report to Treasury Board - H15-20 - (Cliff 1041217)

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To: Scheffel, Emile HLTH:EX
Cc: Docs Processing HLTH:EX; Michell, Jennifer HLTH:EX
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Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Docs Processing HLTH:EX
Sent: Monday, January 4, 2016 10:37 AM
To: HLTH Ministers Office
Cc: Docs Processing HLTH:EX; Andrachuk, Andrea HLTH:EX; Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX; Benbow, Nicole C HLTH:EX
Subject: Progress Report to Treasury Board - H15-20 - Doubling of Hospice Spaces (Cliff 1041217)

Hi All:

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Kathy Simonson
Program Coordinator / DPU / Deputy Minister's Office / Ministry of Health
5-3 1515 Blanshard St, Victoria BC V8W 3C8
Telephone 250 952-0998

kathy.simonson@gov.bc.ca

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:53 AM
To: Andrachuk, Andrea HLTH:EX; Michell, Jennifer HLTH:EX; Docs Processing HLTH:EX
Subject: RE: Request - hospice spaces update

Thanks! Key questions:

- Starting # of beds
- How many added to date
- How many planned by end of 2016

E

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 10:51 AM
To: Scheffel, Emile HLTH:EX; Michell, Jennifer HLTH:EX; Docs Processing HLTH:EX
Subject: RE: Request - hospice spaces update

Hi Emile,
Yes, we'll get that for you.

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:48 AM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Subject: Request - hospice spaces update
Importance: High

Hi there,

Could I please get, by end of day tomorrow, a quick update on bed numbers and timelines for our mandate to double hospice beds by 2020? I have the below, dated Sept 2015.

If there has been a recent update or BN, mind sharing that as well?

Many thanks E

-
- In addition to our Provincial End-of-life Care Action Plan for British Columbia, we are committed to double the number of hospice spaces in the province by 2020.
 - Health authorities are working to meet that mandate.
 - There will be 375 additional hospice spaces, which include dedicated and designated beds and home-based palliative care services in communities across the province.

- to be owned and operated by Providence Health care
- Island Health: 24 beds
 - 8 beds in Comox and Parksville by Fall 2015
 - 3 beds in Campbell River (2016/17)
 - 2 beds in Sooke (2016/17)
 - 4 beds in Cowichan Valley (2017/18)
 - 1 bed in Mt. Waddington (2017/18)
 - 2 beds in Comox Valley (2018/19)
 - 1 bed in Oceanside (2018/19)
 - An additional 11 beds – location to be determined (2019/20)

- Interior Health:
 - Work is underway to determine strategies for optimizing Interior Health's existing bed stock to meet the needs of their rural and remote regions where stand-alone hospices have proved inefficient due to community size.
 - Based on current and projected growth, 30 locations have been identified as needing designated or dedicated beds.
- Northern Health: 10 beds
 - 2 in the Northeast
 - 4 in the Northwest
 - 4 in the Northern Interior

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:48 AM
To: Michell, Jennifer HLTH:EX; Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
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- Health authorities are working to meet that mandate.
- There will be 375 additional hospice spaces, which include dedicated and designated beds and home-based palliative care services in communities across the province.
- 61 beds are proposed for future roll out in each health authority, starting in April 2015, as follows:
 - Fraser Health: 15 beds
 - 10 beds at Holmberg House in Abbotsford (April 2016)
 - 5 beds at Peace Arch Hospice in White Rock (2018/19)
 - Vancouver Coastal Health: 12 beds
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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:46 AM
To: Cadario, Michele PREM:EX
Subject: As requested

Here is what we're communicating publicly right now including bed breakdowns. I have asked for any updates to timelines or additional detail.

E

--

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 - Work is underway to determine strategies for optimizing Interior Health's existing bed stock to meet the needs of their rural and remote regions where stand-alone hospices have proved inefficient due to community size.
 - Based on current and projected growth, 30 locations have been identified as needing designated or dedicated beds.
 - Northern Health: 10 beds
 - 2 in the Northeast
 - 4 in the Northwest

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:25 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

MLA Simons will be here in Vic on Jan. 21 – would sometime that day work?

Thanks E

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 10:07 AM
To: Scheffel, Emile HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Hi Emile,

Yes, staff have provided the below names for the conversation with MLA Simons. Would it be best to work through you to confirm a time with MLA Simons' office? If he provides a few options then we can get everyone on a teleconference.

PPH attendance will be:

- Tamil Kendall – Director, Maternal Health, Public Health Services Branch, Population and Public Health Division
- 250-952-3678, Tamil.Kendall@gov.bc.ca
 - Tamil also would like to extend the invite to:
 - Janice Linton, from HSP as she is the Director responsible for PHSA; and
 - Melanie Foster, Senior Policy Analyst working on early childhood health.

Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:46 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Just checking in on this one ☺

From: Scheffel, Emile HLTH:EX
Sent: Thursday, January 7, 2016 9:42 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Hi there!

Any sense of who/when might be able to connect with MLA?

Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Thanks Emile,
Will do. It will be helpful to know what they are asking in order to determine who would be on the call. Guessing it is MSP coverage.
Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | [email: andrea.andrachuk@gov.bc.ca](mailto:andrea.andrachuk@gov.bc.ca)

From: Scheffel, Emile HLTH:EX
Sent: Monday, January 4, 2016 2:56 PM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: FW: Questions from MLA Simons

Hey folks,

Hoping that MBPSD can make someone available for this in the next couple of weeks – could you please advise?

I have asked for more specific info.

Thanks E

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]
Sent: Monday, January 4, 2016 2:54 PM
To: Scheffel, Emile HLTH:EX
Subject: Questions from MLA Simons

Good afternoon Emile,

MLA Nicholas Simons has asked me to set-up a call or meeting with MoH staff regarding questions he has about children's hearing aids. Can you please confirm a time this would be possible?

Best regards,

Elizabeth Parkinson | Legislative Assistant |
New Democrat Official Opposition Caucus
T: 250.387-1665 | F: 250.387.4680
elizabeth.parkinson@leg.bc.ca | www.bcnepcaucus.ca

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:24 AM
To: 'Thornthwaite, Jane'; Lake, Terry HLTH:EX
Cc: Dhanowa, Damon HLTH:EX
Subject: RE: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hi Jane,

Thought I would give you a quick response as Minister Lake is tied up at an event this morning.

The federal/provincial/territorial component of the meeting will include a pretty heavy focus on the most pressing challenges facing health care systems, as well as on community care – two areas in which we expect mental health will be one of the top issues.

As you know, mental health and particularly CYMH are areas of high priority for us. Looking forward to sharing more info on these conversations following next week's meetings.

Best,

E

From: Thornthwaite, Jane [<mailto:J.Thornthwaite@leg.bc.ca>]
Sent: Tuesday, January 12, 2016 10:16 AM
To: Lake, Terry HLTH:EX
Cc: Scheffel, Emile HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: FW: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Hello Minister. Happy New year!

Just wondering if there is an agenda of this meeting and if Child and Youth Mental Health (or Mental Health in general) is on it. I know that there is a generic high level reference to mental health services in the Federal Health Minister's mandate letter, but I'm wondering if a national program (or provincial transfer funding for mental health initiatives) like Australia's HeadSpace model is being talked about plus a plan for First Nations youth either on or off reserve.

In either case, I'm interested to see how far up this issue is on federal minds.

Thank you so much

Jane

From: Government of British Columbia [<mailto:GCPE.News@gov.bc.ca>]
Sent: January 12, 2016 8:54 AM
To: GCPEMINIS@gov.bc.ca
Subject: MEDIA ADVISORY - federal, provincial and territorial Health Ministers

Jan. 12, 2016

MEDIA ADVISORY - Federal, provincial and territorial Health Ministers

DATES:

On January 20, Minister Lake will host provincial and territorial Health Ministers, while both Ministers Philpott and Lake will co-chair the meeting on January 21.

TIMES:

Wednesday, January 20, 2016 - Provincial-territorial Health Ministers' meeting

7:30 a.m. - Media registration opens

8:30 a.m. - Photo opportunity with Ministers prior to start of meeting

3:15 p.m. - News conference with provincial and territorial Health Ministers

Thursday, January 21, 2016 - Federal-provincial-territorial Health Ministers' meeting

7:00 a.m. - Media registration opens

8:00 a.m. - Photo opportunity with Ministers prior to start of meeting

2:20 p.m. - News conference with federal, provincial and territorial Health Ministers

LOCATION:

All media events will be held at the Fairmont Hotel Vancouver
900 West Georgia Street
Vancouver, B.C.

Media who wish to attend must register upon arrival and obtain accreditation by presenting press identification at the Saturna Island Room.

CONTACTS:

Media Relations
B.C. Ministry of Health
250 952-1887

Media Relations
Health Canada
613 957-2983

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:14 AM
To: Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX
Cc: Thistle-Walker, Carlene GCPE:EX; Dhanowa, Damon HLTH:EX
Subject: RE: Event materials

Did he have the separate itin doc? Or does he just want that incorporated in the SN doc?

From: Robertson, Derek HLTH:EX
Sent: Tuesday, January 12, 2016 10:12 AM
To: Plank, Sarah GCPE:EX
Cc: Scheffel, Emile HLTH:EX; Thistle-Walker, Carlene GCPE:EX; Dhanowa, Damon HLTH:EX
Subject: Event materials

Hey Sarah,

Can we ensure that the Minister's speaking notes include an itinerary for the event? Today's was missing and he commented about it.

Derek

Derek Robertson
Executive Assistant to the Honourable Terry Lake
Minister of Health
Office: (250) 953-3547

Sent from my BlackBerry

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:09 AM
To: Marr, Ann HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: RE: HMM - air ambulance

Perfect thanks – and please forgive my poor info retention as I pull double duty over here ☺

E

From: Marr, Ann HLTH:EX
Sent: Tuesday, January 12, 2016 10:09 AM
To: Scheffel, Emile HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: RE: HMM - air ambulance

Thanks Emile

Ontario will be speaking to the Interprovincial Health Coverage topic at the PT Ministers' private lunch. We briefed the minister on this topic and he was fine with it being raised. The At A Glance document includes Chair notes to introduce the item and the program area's recommended messaging.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:55 AM
To: Marr, Ann HLTH:EX; Poilievre, Tricia HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: HMM - air ambulance

Morning,

I had a chat with my Ontario counterpart today, and he mentioned they'll be doing a little bit of media on their goals and priorities for HMM.

The one thing we should be aware of is that Minister Hoskins may raise the issue of air ambulance coverage between provinces, as a follow up to this case: <http://www.cbc.ca/news/canada/sudbury/ontario-alberta-to-split-air-ambulance-cost-for-out-of-province-claim-1.3195929>

Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 10:09 AM
To: Parkinson, Elizabeth LASS:EX
Subject: RE: Questions from MLA Simons

Good morning Elizabeth,

We will be happy to make our director of maternal health available – could you let me know a few dates and times in the next couple of weeks that would work on your end?

Thanks E

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]
Sent: Monday, January 4, 2016 3:01 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Thank you Emile.

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 4, 2016 3:00 PM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Cc: Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Subject: RE: Questions from MLA Simons

Thanks Elizabeth. I have asked staff to indicate availability.

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]
Sent: Monday, January 4, 2016 2:59 PM
To: Scheffel, Emile HLTH:EX
Subject: RE: Questions from MLA Simons

Thanks Emile. I believe this is about financial coverage for hearing aids for children. Apparently the Lions Club used to help families, but is now unable to provide families that financial assistance.

Elizabeth

From: Scheffel, Emile HLTH:EX [<mailto:Emile.Scheffel@gov.bc.ca>]
Sent: January 4, 2016 2:55 PM
To: Parkinson, Elizabeth <Elizabeth.Parkinson@leg.bc.ca>
Cc: Robertson, Derek HLTH:EX <Derek.Robertson@gov.bc.ca>
Subject: RE: Questions from MLA Simons

Hi Elizabeth,

We'd be happy to set this up.

Is there any more specific info I can pass along to staff to assist them in preparing?

Thanks E

MLA Nicholas Simons has asked me to set-up a call or meeting with MoH staff regarding questions he has about children's hearing aids. Can you please confirm a time this would be possible?

Best regards,

Elizabeth Parkinson | Legislative Assistant |

New Democrat Official Opposition Caucus

T: 250.387-1665 | F: 250.387.4680

elizabeth.parkinson@leg.bc.ca | www.bcndpcaucus.ca

Scheffel, Emile HLTH:EX

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Sent: Tuesday, January 12, 2016 10:07 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Perfect thx, will go back to them now.

E

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 10:07 AM
To: Scheffel, Emile HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Hi Emile,

Yes, staff have provided the below names for the conversation with MLA Simons. Would it be best to work through you to confirm a time with MLA Simons' office? If he provides a few options then we can get everyone on a teleconference.

PPH attendance will be:

- Tamil Kendall – Director, Maternal Health, Public Health Services Branch, Population and Public Health Division
- 250-952-3678, Tamil.Kendall@gov.bc.ca
 - Tamil also would like to extend the invite to:
 - Janice Linton, from HSP as she is the Director responsible for PHSA; and
 - Melanie Foster, Senior Policy Analyst working on early childhood health.

Many thanks,

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Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Just checking in on this one ☺

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Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Hi there!

Any sense of who/when might be able to connect with MLA?

Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Thanks Emile,
Will do. It will be helpful to know what they are asking in order to determine who would be on the call. Guessing it is MSP coverage.
Thanks,

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Office of the Deputy Minister
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To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: FW: Questions from MLA Simons

Hey folks,

Hoping that MBPSD can make someone available for this in the next couple of weeks – could you please advise?

I have asked for more specific info.

Thanks E

From: Parkinson, Elizabeth [<mailto:Elizabeth.Parkinson@leg.bc.ca>]
Sent: Monday, January 4, 2016 2:54 PM
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Good afternoon Emile,

MLA Nicholas Simons has asked me to set-up a call or meeting with MoH staff regarding questions he has about children's hearing aids. Can you please confirm a time this would be possible?

Best regards,

Elizabeth Parkinson | Legislative Assistant |
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Morning,

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The one thing we should be aware of is that Minister Hoskins may raise the issue of air ambulance coverage between provinces, as a follow up to this case: <http://www.cbc.ca/news/canada/sudbury/ontario-alberta-to-split-air-ambulance-cost-for-out-of-province-claim-1.3195929>

Thanks E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:54 AM
To: 'Cherie Payne (BCPhA)'
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Thanks Cherie and likewise.

E

-----Original Message-----

From: Cherie Payne (BCPhA) [mailto:cherie.payne@bcpharmacy.ca]
Sent: Tuesday, January 12, 2016 9:53 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Congratulations - glad we'll get to work together before you take on your new role

-----Original Message-----

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January-12-16 9:51 AM
To: Cherie Payne (BCPhA) <cherie.payne@bcpharmacy.ca>
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Much appreciated.

Difficult to say re Minister Philpott -- but I suspect more options is better as she likely has a heavy calendar next week already.

Our chief, Katy, has moved on to a new job in the Premier's Office -- so I'm doing double duty for the foreseeable future, or at least until I leave to my new job at the end of the month.

Will absolutely let you know when we have new staff to announce.

E

-----Original Message-----

From: Cherie Payne (BCPhA) [mailto:cherie.payne@bcpharmacy.ca]
Sent: Tuesday, January 12, 2016 9:48 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Draft January 19th Media Event – Immunising Refugees

We can make the week of the 25th work and have a spokesperson available; do you think Minister Philpott would fly to Vancouver twice?

I hear there are some staffing changes coming to your MO - any replacements announced yet?

-----Original Message-----

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January-12-16 9:20 AM
To: Cherie Payne (BCPhA) <cherie.payne@bcpharmacy.ca>
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Many thanks E

-----Original Message-----

From: Cherie Payne (BCPhA) [mailto:cherie.payne@bcpharmacy.ca]
Sent: Monday, January 11, 2016 10:36 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Sounds good!

-----Original Message-----

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January-08-16 5:23 PM
To: Cherie Payne (BCPhA) <cherie.payne@bcpharmacy.ca>
Cc: Angie Gaddy (BCPhA) <angie.gaddy@bcpharmacy.ca>
Subject: Re: Draft January 19th Media Event – Immunising Refugees

Thanks for this, Cherie, and to all of you for your time earlier.

I'll circulate this to folks on our end Monday morning when everybody's fresh.

Have a great weekend.

E

From: Cherie Payne (BCPhA)
Sent: Friday, January 8, 2016 5:21 PM
To: Scheffel, Emile HLTH:EX
Cc: Angie Gaddy (BCPhA)
Subject: Draft January 19th Media Event – Immunising Refugees

Subject: January 19th Media Event – Immunising Refugees

What: Media event for Minister Lake, Geraldine Vance (CEO, BCPhA), Pharmacist Mohamed Kayed, and family to be immunised, (tentative: Minister Philpott)

Where: On-site at Shoppers Drug Mart Pharmacy
18677 Fraser Highway, Surrey, BC

When: 10am Tuesday January 19, 2016
(Alternate date: Monday January 18)

Event Description:

- Media would get photo and B-roll of a newly arrived refugee family being immunised by pharmacist Mohamed Kayed who has deep roots in the community and has been active in providing orientation, facilitating healthcare and housing for newcomer refugees as a leader in the BC Muslim Association. He is also a long time member of the BC Pharmacy Association as is his pharmacy Shoppers Drug Mart. He has identified a suitable family for the event, and BC Pharmacy Association will vet/prepare the group in advance of the event.

- The event would open with introductory remarks from Minister Lake, Geraldine Vance, (tentative: Minister Philpott) highlighting the range of health needs incoming refugees face, the service the provincial government is

Talking Points:

- BC Pharmacy Association is available to draft speaking notes and news release for event
- The news release would communicate: the partnership work underway, the need for refugees to be vaccinated, that pharmacies across the province are available to receive patients, the federal funding available (should Minister Philpott join).

Cherie Payne, BA, LL.B
Manager of Public Affairs, BC Pharmacy Association
604.269.2858
@CheriePayne

Scheffel, Emile HLTH:EX

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Sent: January-12-16 9:20 AM
To: Cherie Payne (BCPhA) <cherie.payne@bcpharmacy.ca>
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Morning Cherie,

Quick update for you --i have shared this with the federal minister's office to get a sense of their interest and availability. I'm speaking with their chief on the phone tomorrow but will hopefully get an answer before then.

In the meantime, what I'm hearing from folks on our end is that the week of Jan. 25th would be preferable -- would this still work for you?

Many thanks E

-----Original Message-----

From: Cherie Payne (BCPhA) [mailto:cherie.payne@bcpharmacy.ca]
Sent: Monday, January 11, 2016 10:36 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Thanks for this, Cherie, and to all of you for your time earlier.

I'll circulate this to folks on our end Monday morning when everybody's fresh.

Have a great weekend.

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- The event would open with introductory remarks from Minister Lake, Geraldine Vance, (tentative: Minister Philpott) highlighting the range of health needs incoming refugees face, the service the provincial government is providing, the funding being provided by the federal government for immunisations and health services, and the opportunity to expand those services through partnership across the health sector.
- Beyond the photo op, BC Pharmacy Association would use the date to host a 2-3 hour health clinic on site at the pharmacy so that other families could receive vaccinations. Media would secure B-roll of the Minister and Geraldine Vance (and Minister Philpott) interacting with families.

Talking Points:

- BC Pharmacy Association is available to draft speaking notes and news release for event
- The news release would communicate: the partnership work underway, the need for refugees to be vaccinated, that pharmacies across the province are available to receive patients, the federal funding available (should Minister Philpott join).

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:46 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Just checking in on this one ☺

From: Scheffel, Emile HLTH:EX
Sent: Thursday, January 7, 2016 9:42 AM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Hi there!

Any sense of who/when might be able to connect with MLA?

We'd like to have someone from MO participate.

Thanks! E

From: Andrachuk, Andrea HLTH:EX
Sent: Monday, January 4, 2016 3:52 PM
To: Scheffel, Emile HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: RE: Questions from MLA Simons

Thanks Emile,
Will do. It will be helpful to know what they are asking in order to determine who would be on the call. Guessing it is MSP coverage.
Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Monday, January 4, 2016 2:56 PM
To: Andrachuk, Andrea HLTH:EX; Docs Processing HLTH:EX
Cc: Robertson, Derek HLTH:EX
Subject: FW: Questions from MLA Simons

Hey folks,

Hoping that MBPSD can make someone available for this in the next couple of weeks – could you please advise?

I have asked for more specific info.

Thanks E

MLA Nicholas Simons has asked me to set-up a call or meeting with MoH staff regarding questions he has about children's hearing aids. Can you please confirm a time this would be possible?

Best regards,

Elizabeth Parkinson | Legislative Assistant |
New Democrat Official Opposition Caucus
T: 250.387-1665 | F: 250.387.4680
elizabeth.parkinson@leg.bc.ca | www.bcndpcaucus.ca

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:45 AM
To: Michell, Jennifer HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: e-Prescribing

Sounds good thx, will let him know.

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 9:39 AM
To: Scheffel, Emile HLTH:EX; Feulgen, Sabine HLTH:EX
Subject: RE: e-Prescribing

If we can have this conversation occur right after the CCST briefing as Deb Shera will be on the phone for this meeting that would be ideal as she is well versed in ePrescribing.

Thanks so much
Jen

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

Warning: This email is intended only for the use of the individual or organization to whom it is addressed. It may contain information that is privileged or confidential. Any distribution, disclosure, copying, or other use by anyone else is strictly prohibited. If you have received this in error, please telephone or e-mail the sender immediately and delete the message.

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:29 AM
To: Michell, Jennifer HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Stearn, Anne HLTH:EX
Subject: RE: e-Prescribing

Way better idea – thanks.

I will let him know that Sabine can give him a quick update this afternoon.

E

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 9:27 AM
To: Scheffel, Emile HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Stearn, Anne HLTH:EX
Subject: RE: e-Prescribing

Hi Emile

Sabine is actually meeting in person with the Minister this afternoon on two other items. Perhaps they can connect following one of those briefings? She has one from 1:30-2 and the other from 2:15-2:45

Jennifer Michell
Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

Cc: Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX
Subject: e-Prescribing

Good morning!

MTL asked that I share the below article and check in for an update on e-Prescribing.

Does one of you have a few minutes later today?

Many thanks,

E

Island Health launches paperless record system in Nanaimo

Nanaimo News Bulletin

Monday, January 11, 2016

Page 4

By Tamara Cunningham

Patient records are about to go paperless as Island **Health** launches a new electronic medical record system in Nanaimo.

Nanaimo will be ground zero for IHealth, the **health** authority's new \$178-million medical system, set to roll out this February.

Paper charts have to be faxed to other offices and there can also be medication errors because of poor handwriting, according to IHealth executive director Suzanne Fox, who says the change is all about improving quality for patients.

The initiative will bank patients' medical history in one place, allowing professionals like pharmacists, occupational therapists and physicians to access and add to the same record. Patients will no longer have to carry around paper and doctors will also be able to enter orders for patients themselves if there's a need for chest x-rays or blood work, instead of writing it on a piece of paper for a unit clerk to transcribe. It's instant and eliminates wait time for patients, Fox said.

"We know when patients transition care they go from a hospital back to home, or a hospital visit to their GP's office, there's sometimes missed information because it's verbal or handwritten. Now it's in that one place," she said

Nanaimo was initially supposed to hook into IHealth last June, but the system wasn't ready, Fox said. Local ancillary **health** services like labs and pharmacies will be the first to see the electronic system, Feb. 21. Nanaimo Regional General Hospital and Dufferin residential care will log in on March. 19.

Eventually the idea is to see the system Island-wide.

The system excludes doctors' offices which are independent of Island **Health**.

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:39 AM
To: Steve Vander Wal
Subject: Re: Meeting Request - Innovation Arthritis Triage

Hey Steve I'm told a meeting is in the works for early Feb. Let me know if you need anything else.

Thanks E

From: Steve Vander Wal
Sent: Monday, January 11, 2016 10:30 AM
To: Scheffel, Emile HLTH:EX
Subject: FW: Meeting Request - Innovation Arthritis Triage

FYI – note sent to ADM Doug Hughes' office. any assistance to help keep this on track appreciated. I didn't mention Kevin's meeting with you directly though it is referenced at the bottom of the email. Thanks in advance.

From: Steve Vander Wal
Sent: Monday, January 11, 2016 10:29 AM
To: 'Carol.hoyer@gov.bc.ca' <Carol.hoyer@gov.bc.ca>; 'tamara.casanova@gov.bc.ca' <tamara.casanova@gov.bc.ca>
Cc: Kevin Harrington (Kevin.Harrington@abbvie.com) <Kevin.Harrington@abbvie.com>
Subject: FW: Meeting Request - Innovation Arthritis Triage

Carol and Tamara – Dr. Kam Shojania and Kevin Harrington look forward to meeting with ADM Doug Hughes to discuss and innovative care model to improve arthritis patient outcomes (one of the top chronic diseases in BC) while reducing system costs.

Attached is a presentation that outlines Dr. Shojania's innovative proposal to develop and utilize a qualified online triage tool to deliver better, more efficient and cost -effective arthritis care in BC.

I understand ADM Hughes' time is in high demand but I can assure you this innovative proposal aligns well with the government's priorities related to more efficient use of physician resources, better rural access to care and reduced waiting times.

Given the work ahead they hope the meeting can happen in the coming weeks so please let us know about availability. Thanks!

From: Crisp, Leah HLTH:EX [<mailto:Leah.Crisp@gov.bc.ca>]
Sent: Monday, January 11, 2016 10:10 AM
To: Steve Vander Wal <Steve.VanderWal@hkstrategies.ca>
Cc: Crisp, Leah HLTH:EX <Leah.Crisp@gov.bc.ca>
Subject: RE: Meeting Request - Innovation Arthritis Triage

Good morning Steve;

Carol Hoyer, from Doug Hughes' office is the person to contact regarding the meeting. Her email address is:

Carol.hoyer@gov.bc.ca

From: Steve Vander Wal [<mailto:Steve.VanderWal@hkstrategies.ca>]
Sent: Tuesday, January 5, 2016 11:24 AM
To: Crisp, Leah HLTH:EX
Subject: FW: Meeting Request - Innovation Arthritis Triage

From: Harrington, Kevin K [<mailto:Kevin.Harrington@abbvie.com>]
Sent: Wednesday, December 16, 2015 2:41 PM
To: doug.hughes@gov.bc.ca; Heather Davidson <heather.davidson@gov.bc.ca>
Cc: Dr. Kam Shojania s.22 ; Carol D Hoyer <Carol.Hoyer@gov.bc.ca>; lisa.clout@gov.bc.ca;
leah.crisp@gov.bc.ca
Subject: Meeting Request - Innovation Arthritis Triage

Dear Mr. Hughes & Ms. Davidson,

I understand there has been some recent discussion around consideration of the meeting request below, originally sent to Lynn Stevenson and Heather Davidson.

I wanted to reach out to let you know that Dr. Kam Shojania and I are available to come to Victoria next week, if you would be available to meet. We are excited to discuss an innovative arthritis care model for BC that will provide system efficiencies and important savings while improving patient access to appropriate care. We look forward to meeting with you both.

Please let me know if you require any information while you consider our request. We appreciate your consideration of this request.

Thank you,
Kevin

KEVIN HARRINGTON
Sr. Manager - Provincial Affairs & Health Policy
British Columbia

From: Harrington, Kevin K [<mailto:Kevin.Harrington@abbvie.com>]
Sent: Thursday, December 10, 2015 11:20 AM
To: Lynn.Stevenson@gov.bc.ca; Heather Davidson (heather.davidson@gov.bc.ca)
<heather.davidson@gov.bc.ca>
Cc: Kam Shojania s.22
Subject: FW: Meeting request - Arthritis Triage

Lynn and Heather – I am sure you are both very busy going into Christmas. As a follow-up to my meeting request last week, I wanted to let you know that Dr. Shojania and I are available to come to Victoria at your convenience to present a very promising opportunity that will significantly improve the models of care in arthritis leading to improvements in patient outcomes while generating significant mid-to-long term savings for Pharmacare and for health authorities.

In case there is room in your calendar the last week before the holiday, Dr. Shojania and I will reorganize our schedules to meet with you on either Monday Dec 21, Tuesday Dec 22 or Wednesday Dec 23. We would appreciate if can let us know if any of these dates can work.

From: Harrington, Kevin K
Sent: December-02-15 4:22 PM
To: Lynn.Stevenson@gov.bc.ca; Heather Davidson (heather.davidson@gov.bc.ca)
Cc: Kam Shojania ^{s.22}
Subject: Meeting request - Arthritis Triage

Lynn and Heather – I am following up on a conversation that I had with Emile Scheffel in Minister Lake's office regarding an innovative care model to improve arthritis patient outcomes (one of the top chronic diseases in BC) while reducing system costs and he suggested that I book a meeting with you. Attending would be Dr. Kam Shojania, Clinical Professor and Head, Division of Rheumatology UBC and myself. I have included his contact information at the bottom of this email. We would like to discuss Dr. Shojania's innovative proposal to develop and utilize a qualified online triage tool to deliver better, more efficient and cost-effective arthritis care in BC (**overview slides attached**). **We are able to travel to Victoria on Wednesday December 9th or Wednesday December 16th. If those dates don't work for you we can meet most other week days before or after regular business hours in Vancouver or Victoria.**

As you know, there are very long waits to access a rheumatologist in BC (9 months to 1 year) though clinical practice guidelines strongly suggest most arthritis patients do not need to see a specialist. Access for patients with rheumatoid arthritis particularly those in rural BC can be especially challenging given the majority of the 64 rheumatologists in the province are located in Metro Vancouver. Also, arthritis costs for BC have been rising steadily due to hip and knee surgeries for osteoarthritis and delays in access to appropriate drug therapy to effectively treat rheumatoid arthritis (and related forms inflammatory arthritis).

I look forward to your reaction and welcome any questions you might have.

Thank you,

Kevin

KEVIN HARRINGTON

Sr. Manager - Provincial Affairs & Health Policy

British Columbia

<image001.png>

AbbVie Corporation

OFFICE [604-929-9155](tel:604-929-9155)

CELL [604-417-5280](tel:604-417-5280)

EMAIL kevin.harrington@abbvie.com

abbvie.com

Kam Shojania, MD, FRCPC

Clinical Professor and Head,

Postgraduate Program Director,

Division of Rheumatology

University of British Columbia

#802 - 1200 Burrard Street

Vancouver, BC Canada V6Z 2C7

t:[604-806-9400](tel:604-806-9400)

f:[604-269-3736](tel:604-269-3736)

email: ^{s.22}

www.ubc-rheumatology.com

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:38 AM
To: Andrachuk, Andrea HLTH:EX
Subject: Re: Proposal - Electronic Arthritis Triage Strategy (EATS)

Ok thanks!

From: Andrachuk, Andrea HLTH:EX
Sent: Tuesday, January 12, 2016 9:37 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hi Emile,
Doug's team has now been in communication with Steve Vander Wal (he assists Dr. Shojania & Kevin Harrington with their calendars). It sounds like they are looking for a time to meet in early February now.

Thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Monday, January 11, 2016 10:32 AM
To: Andrachuk, Andrea HLTH:EX
Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hi Andrea,

Happy Monday – following up on this as the stakeholder is following up with me.

Thanks E

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 5, 2016 11:32 AM
To: Andrachuk, Andrea HLTH:EX
Cc: Merrifield, Katy HLTH:EX
Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hi Andrea,

Do you know where this landed?

Just chatted with the stakeholder, and they would be happy to do a preliminary meeting below Doug's level to help move this forward. Preference is definitely in January.

Thanks E

From: Andrachuk, Andrea HLTH:EX

Many thanks,

Andrea Andrachuk | Manager/Executive Operations
Office of the Deputy Minister
Ministry of Health

P: 250.952.1908 | C: 250.217.3655 | email: andrea.andrachuk@gov.bc.ca

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, December 1, 2015 5:18 PM
To: Stevenson, Lynn HLTH:EX; Walman, Barbara J. HLTH:EX; Hughes, Doug J HLTH:EX; Davidson, Heather (ADM) HLTH:EX
Cc: Merrifield, Katy HLTH:EX; Foran, Grace E HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: RE: Proposal - Electronic Arthritis Triage Strategy (EATS)

Sorry for the second email – I meant to include Heather the first time.

E

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, December 1, 2015 5:17 PM
To: Stevenson, Lynn HLTH:EX; Walman, Barbara J. HLTH:EX; Hughes, Doug J HLTH:EX
Cc: Merrifield, Katy HLTH:EX; Foran, Grace E HLTH:EX; Andrachuk, Andrea HLTH:EX
Subject: Proposal - Electronic Arthritis Triage Strategy (EATS)

Hey folks,

I spoke today with Kevin Harrington of AbbVie, who took me through the attached slide deck proposing a new system to better triage arthritis patients and make better use of the available rheumatologists.

It is supported by Dr. Kam Shojania of the UBC rheumatology division.

I am hoping we could get your take on it, and that one or more of you might make yourselves available to hear from Kevin/Dr. Shojania directly.

Lynn, I think Kevin will also be getting in touch with you.

Many thanks in advance,

E

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:29 AM
To: Michell, Jennifer HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Stearn, Anne HLTH:EX
Subject: RE: e-Prescribing

Way better idea – thanks.

I will let him know that Sabine can give him a quick update this afternoon.

E

From: Michell, Jennifer HLTH:EX
Sent: Tuesday, January 12, 2016 9:27 AM
To: Scheffel, Emile HLTH:EX; Feulgen, Sabine HLTH:EX
Cc: Stearn, Anne HLTH:EX
Subject: RE: e-Prescribing

Hi Emile

Sabine is actually meeting in person with the Minister this afternoon on two other items. Perhaps they can connect following one of those briefings? She has one from 1:30-2 and the other from 2:15-2:45

Jennifer Michell

Manager, Corporate Services
Office of the Associate Deputy Minister, Corporate Services | Ministry of Health

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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:13 AM
To: Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX
Cc: Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX
Subject: e-Prescribing

Good morning!

MTL asked that I share the below article and check in for an update on e-Prescribing.

Does one of you have a few minutes later today?

Many thanks,

E

Island Health launches paperless record system in Nanaimo

Nanaimo News Bulletin

Monday, January 11, 2016

Page 4

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:20 AM
To: 'Cherie Payne (BCPhA)'
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Morning Cherie,

Quick update for you --I have shared this with the federal minister's office to get a sense of their interest and availability. I'm speaking with their chief on the phone tomorrow but will hopefully get an answer before then.

In the meantime, what I'm hearing from folks on our end is that the week of Jan. 25th would be preferable -- would this still work for you?

Many thanks E

-----Original Message-----

From: Cherie Payne (BCPhA) [mailto:cherie.payne@bcpharmacy.ca]
Sent: Monday, January 11, 2016 10:36 AM
To: Scheffel, Emile HLTH:EX
Subject: RE: Draft January 19th Media Event – Immunising Refugees

Sounds good!

-----Original Message-----

From: Scheffel, Emile HLTH:EX [mailto:Emile.Scheffel@gov.bc.ca]
Sent: January-08-16 5:23 PM
To: Cherie Payne (BCPhA) <cherie.payne@bcpharmacy.ca>
Cc: Angie Gaddy (BCPhA) <angie.gaddy@bcpharmacy.ca>
Subject: Re: Draft January 19th Media Event – Immunising Refugees

Thanks for this, Cherie, and to all of you for your time earlier.

I'll circulate this to folks on our end Monday morning when everybody's fresh.

Have a great weekend.

E

From: Cherie Payne (BCPhA)
Sent: Friday, January 8, 2016 5:21 PM
To: Scheffel, Emile HLTH:EX
Cc: Angie Gaddy (BCPhA)
Subject: Draft January 19th Media Event – Immunising Refugees

Subject: January 19th Media Event – Immunising Refugees

What: Media event for Minister Lake, Geraldine Vance (CEO, BCPhA), Pharmacist Mohamed Kayed, and family to be immunised, (tentative: Minister Philippott)

- Media would get photo and B-roll of a newly arrived refugee family being immunised by pharmacist Mohamed Kayed who has deep roots in the community and has been active in providing orientation, facilitating healthcare and housing for newcomer refugees as a leader in the BC Muslim Association. He is also a long time member of the BC Pharmacy Association as is his pharmacy Shoppers Drug Mart. He has identified a suitable family for the event, and BC Pharmacy Association will vett/prep the group in advance of the event.
- The event would open with introductory remarks from Minister Lake, Geraldine Vance, (tentative: Minister Philpott) highlighting the range of health needs incoming refugees face, the service the provincial government is providing, the funding being provided by the federal government for immunisations and health services, and the opportunity to expand those services through partnership across the health sector.
- Beyond the photo op, BC Pharmacy Association would use the date to host a 2-3 hour health clinic on site at the pharmacy so that other families could receive vaccinations. Media would secure B-roll of the Minister and Geraldine Vance (and Minister Philpott) interacting with families.

Talking Points:

- BC Pharmacy Association is available to draft speaking notes and news release for event
- The news release would communicate: the partnership work underway, the need for refugees to be vaccinated, that pharmacies across the province are available to receive patients, the federal funding available (should Minister Philpott join).

Cherie Payne, BA, LL.B
Manager of Public Affairs, BC Pharmacy Association
604.269.2868
@CheriePayne

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:18 AM
To: 'Hinse, Geneviève (HC/SC)'
Cc: 'Boyle, Danielle (HC/SC)'
Subject: Draft Media Event – Immunising Refugees

Hello Genevieve,

Looking forward to connecting tomorrow.

Sharing this with you in advance as it is a bit time sensitive – the BC Pharmacy Association (BCPhA) has come to us with an event proposal to highlight their work around providing immunization and other health supports to incoming refugees.

We are looking at the possibility of Jan. 19th or sometime in the week of the 25th.

We would welcome Minister Philpott to attend and participate if interested and available.

Could you let me know whether you folks might be interested?

Thanks E

--

What: Media event for Minister Lake, Geraldine Vance (CEO, BCPhA), Pharmacist Mohamed Kayed, and family to be immunised, (tentative: Minister Philpott)

Where: On-site at Shoppers Drug Mart Pharmacy
18677 Fraser Highway, Surrey, BC

When: TBD

Event Description:

- Media would get photo and B-roll of a newly arrived refugee family being immunised by pharmacist Mohamed Kayed who has deep roots in the community and has been active in providing orientation, facilitating healthcare and housing for newcomer refugees as a leader in the BC Muslim Association. He is also a long time member of the BC Pharmacy Association as is his pharmacy Shoppers Drug Mart. He has identified a suitable family for the event, and BC Pharmacy Association will vet/prepare the group in advance of the event.
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From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 9:13 AM
To: Feulgen, Sabine HLTH:EX; Shera, Deborah HLTH:EX
Cc: Stearn, Anne HLTH:EX; Michell, Jennifer HLTH:EX
Subject: e-Prescribing

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Many thanks,

E

Island Health launches paperless record system in Nanaimo

Nanaimo News Bulletin

Monday, January 11, 2016

Page 4

By Tamara Cunningham

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 8:12 AM
To: Lake, Terry HLTH:EX
Cc: Robertson, Derek HLTH:EX; Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Subject: CCS palliative care study
Attachments: End-of-life care - Sept 2015_CM.docx; End-of-Life Care Supplemental - Sept 2015_CM.docx

Morning Minister,

KMs attached in case you get a question on this CCS study today.

I read through it, there is no specific mention of BC and only Quebec is singled out for praise as they have a legislated obligation to provide palliative care to cancer patients.

Will share with PCC crew as well.

E

From: tno@gov.bc.ca
Sent: Tuesday, January 12, 2016 7:45 AM
Subject: CBCV: Miller - palliative care

CBCV (CBC Victoria)
CBC On the Island
12-Jan-2016 06:49

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CORE MESSAGING

Updated: September 2015

Ministry of Health

END-OF-LIFE CARE

- Premier Clark has given me a mandate to improve palliative and end-of-life care by building hospice capacity and partnering with those who support the health care system, and this important work is underway.
- Availability of palliative and end-of-life care becomes increasingly important as the population grows and ages.
- In future, the challenge of providing critical care services will become greater due to increasing numbers of people dying, increasing age of family caregivers and decreasing number of available caregivers.
- Our goal is to double the number of hospice spaces in B.C. by 2020.
- The ministry released the *Provincial End-of-life Care Action Plan for British Columbia* in March 2013. It was developed in consultation with clinical experts, community stakeholders, policy leaders and service providers and identifies three priority areas: delivery of timely co-ordinated end-of-life care; provision of education tools and resources to patients, caregivers and health care providers; and strengthening accountability and efficiency.
- At the same time, government, through the Provincial Health Services Authority, provided \$2 million to establish the BC Centre for Palliative Care.
- The centre is accelerating innovation and best practice in end-of-life care for people with life limiting illnesses by focusing on improving access to palliative care supports, enabling excellence through support for health professionals, and mobilizing citizen engagement to promote compassionate communities.
- In 2011, B.C.'s laws for incapacity planning changed to give capable adults more options to make their wishes for future health care known – including end-of-life care – by naming a representative and/or making an advance directive without needing to visit a lawyer or notary public.

- In 2012, the ministry led the implementation of advance care planning and advance directives in the province, and is currently working with the BC Centre for Palliative Care to refine the guide and develop tools and resources to facilitate their use.

Facts about End-of-life Care

- We know most people would prefer to spend their final days at home with friends and family around them. In 2014, about 56% of people who died of natural causes in B.C. spent their final days at home, in residential care or in hospice (compared to about 44% in 2003).
- The baseline measure for hospice spaces is 375 beds. As of March 2015, it consists of 87 acute/tertiary palliative care unit beds and 288 community hospice beds.
- Hospice spaces also include home-based palliative care services for those individuals who wish to die at home. Baseline measures and targets are being established.
- B.C. Palliative Care Benefits support B.C. residents who choose to die at home with the same drug coverage they would receive if they were in hospital, and with the necessary supplies and equipment.
- Approximately 88,000 patients have received these benefits since the program started in 2001. In 2014/15, \$17.5 million was spent on medications and pharmacy dispensing fees, up from \$3.9 million in 2001/02.
- We offer joint training for doctors and other health care professionals in palliative care. We also offer incentive payments to family physicians caring for patients with palliative needs.
- HealthLink BC also provides an after-hours palliative service, which provides triage and support to palliative care patients who are being cared for at home.
- End-of-life care is also identified as a priority under the Primary Health Care Charter.

Investment in hospice:

In 2015, we provided funding of:

- \$2.5 million to the Abbotsford Hospice Society to support the completion of Holmberg House, a new adult hospice.

In 2014, we announced funding of:

- \$40,000 to the North Thompson Valley Hospice House Society to conduct a feasibility study to develop hospice care.
- \$250,000 to the St. Joseph's Hospital Foundation to support four new hospice beds in Comox.
- \$40,000 to the Oceanside Hospice Society to help support end-of-life care services.

In 2013, we announced funding of:

- \$950,000 to Vancouver Hospice Society to allow the new hospice home to become fully operational.
- \$2 million to support a new, permanent home for Marion Hospice in Vancouver.
- \$2 million to Canuck Place Children's Hospice
- \$3 million for the expansion of Peace Arch Hospice in White Rock.

In 2012, we announced funding of:

- \$1.5 million to Canuck Place Children's Hospice

In 2011, we announced funding of:

- \$3.5 million to the Abbotsford Hospice Society

CORE MESSAGING

Updated: September 2015

Ministry of Health

END-OF-LIFE CARE SUPPLEMENT

- In addition to our Provincial End-of-life Care Action Plan for British Columbia, we are committed to double the number of hospice spaces in the province by 2020.
- Health authorities are working to meet that mandate.
- There will be 375 additional hospice spaces, which include dedicated and designated beds and home-based palliative care services in communities across the province.
- 61 beds are proposed for future roll out in each health authority, starting in April 2015, as follows:
 - Fraser Health: 15 beds
 - 10 beds at Holmberg House in Abbotsford (April 2016)
 - 5 beds at Peace Arch Hospice in White Rock (2018/19)
 - Vancouver Coastal Health: 12 beds
 - to be owned and operated by Providence Health care
 - Island Health: 24 beds
 - 8 beds in Comox and Parksville by Fall 2015
 - 3 beds in Campbell River (2016/17)
 - 2 beds in Sooke (2016/17)
 - 4 beds in Cowichan Valley (2017/18)
 - 1 bed in Mt. Waddington (2017/18)
 - 2 beds in Comox Valley (2018/19)
 - 1 bed in Oceanside (2018/19)
 - An additional 11 beds – location to be determined (2019/20)

- Interior Health:
 - Work is underway to determine strategies for optimizing Interior Health's existing bed stock to meet the needs of their rural and remote regions where stand-alone hospices have proved inefficient due to community size.
 - Based on current and projected growth, 30 locations have been identified as needing designated or dedicated beds.
- Northern Health: 10 beds
 - 2 in the Northeast
 - 4 in the Northwest
 - 4 in the Northern Interior

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 8:11 AM
To: Oliphant, Sam PREM:EX; Merrifield, Katy PREM:EX
Cc: Ives, Andrew PREM:EX
Subject: CCS Palliative care study
Attachments: End-of-life care - Sept 2015_CM.docx

Just in case this comes up today.

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- The baseline measure for hospice spaces is 375 beds. As of March 2015, it consists of 87 acute/tertiary palliative care unit beds and 288 community hospice beds.
- Hospice spaces also include home-based palliative care services for those individuals who wish to die at home. Baseline measures and targets are being established.
- B.C. Palliative Care Benefits support B.C. residents who choose to die at home with the same drug coverage they would receive if they were in hospital, and with the necessary supplies and equipment.
- Approximately 88,000 patients have received these benefits since the program started in 2001. In 2014/15, \$17.5 million was spent on medications and pharmacy dispensing fees, up from \$3.9 million in 2001/02.
- We offer joint training for doctors and other health care professionals in palliative care. We also offer incentive payments to family physicians caring for patients with palliative needs.
- HealthLink BC also provides an after-hours palliative service, which provides triage and support to palliative care patients who are being cared for at home.
- End-of-life care is also identified as a priority under the Primary Health Care Charter.

Investment in hospice:

In 2015, we provided funding of:

- \$2.5 million to the Abbotsford Hospice Society to support the completion of Holmberg House, a new adult hospice.

In 2014, we announced funding of:

- \$40,000 to the North Thompson Valley Hospice House Society to conduct a feasibility study to develop hospice care.
- \$250,000 to the St. Joseph's Hospital Foundation to support four new hospice beds in Comox.
- \$40,000 to the Oceanside Hospice Society to help support end-of-life care services.

In 2013, we announced funding of:

- \$950,000 to Vancouver Hospice Society to allow the new hospice home to become fully operational.
- \$2 million to support a new, permanent home for Marion Hospice in Vancouver.
- \$2 million to Canuck Place Children's Hospice
- \$3 million for the expansion of Peace Arch Hospice in White Rock.

In 2012, we announced funding of:

- \$1.5 million to Canuck Place Children's Hospice

In 2011, we announced funding of:

- \$3.5 million to the Abbotsford Hospice Society

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 8:09 AM
To: Leake, Greg HLTH:EX
Subject: Re: VCH client complaint

No worries at all. We are really glad to have you on the team in this critical role, especially after hearing feedback from Env folks.

Let me know if there's anything we can do on our end to make your life easier.

E

Original Message
From: Leake, Greg HLTH:EX
Sent: Tuesday, January 12, 2016 8:05 AM
To: Scheffel, Emile HLTH:EX
Subject: Re: VCH client complaint

Emile:

Thanks for the welcome! I'm looking forward to it.

Sorry it took a bit to get back to you -- I'm without either a laptop or an iPhone so far, so I'm tied to my desktop for email during the day. But this too shall pass!

Cheers,
G.

From: Scheffel, Emile HLTH:EX
Sent: January-11-16 4:32 PM
To: Downey, Gayle F HLTH:EX; Leake, Greg HLTH:EX; Docs Processing HLTH:EX
Cc: Stearn, Anne HLTH:EX; Andrachuk, Andrea HLTH:EX; McCormick, Erika HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: VCH client complaint

That would be great, thx!

E

-----Original Message-----
From: Downey, Gayle F HLTH:EX
Sent: Monday, January 11, 2016 4:32 PM
To: Scheffel, Emile HLTH:EX; Leake, Greg HLTH:EX; Docs Processing HLTH:EX
Cc: Stearn, Anne HLTH:EX; Andrachuk, Andrea HLTH:EX; McCormick, Erika HLTH:EX; Robertson, Derek HLTH:EX
Subject: RE: VCH client complaint

Yes, we will look into this Emile. Do you want a report back?

Kathy if you haven't already assigned, please direct to Anna-Maria. Thanks!

Gayle

Hey folks,

And welcome to the team, Greg.

Could I ask you to take a look at the below, have someone reach out to the client and to VCH if necessary?

Thanks E

-----Original Message-----

From: s.22

Sent: January 11, 2016 2:58 PM

To: premier@gov.bc.ca

Cc: Lake.MLA, Terry <Terry.Lake.MLA@leg.bc.ca>

Subject: VCH Review Panel

Maureen Sexsmith

Robert and Lily Lee Family

Community Health Centre

#210-1669 E. Broadway

Vancouver BC V5N 1V9

December 16, 2015

s.22

For the Review Panel:

Re: Reassessment to provide adequate home care help so I will be safe in my home.

Introduction

s.22

Page 1085

Withheld pursuant to/removed as

s.22

Yours truly,

s.22

(1) Vancouver Community Mental Health Services , Clinical Policies and Procedures Manual, page 3: "vulnerable Adult; an individual who is physically and/or mentally disabled".

(2) Vancouver Community Mental Health Services, Clinical Policies & Procedures Manual: Neglect--Any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage to or loss of assets ...

s.22

Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:59 AM
To: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: RE: CBCV: Miller - palliative care

Sorry I mean palliative care

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:53 AM
To: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: Fw: CBCV: Miller - palliative care

Could you pls flip me our KMs on EOL care for this morning?

Thanks E

From: tno@gov.bc.ca
Sent: Tuesday, January 12, 2016 7:45 AM
Subject: CBCV: Miller - palliative care

CBCV (CBC Victoria)
CBC On the Island
12-Jan-2016 06:49

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Scheffel, Emile HLTH:EX

From: Scheffel, Emile HLTH:EX
Sent: Tuesday, January 12, 2016 7:53 AM
To: Plank, Sarah GCPE:EX; Heinze, Laura R GCPE:EX
Cc: Robertson, Derek HLTH:EX; Dhanowa, Damon HLTH:EX
Subject: Fw: CBCV: Miller - palliative care

Could you pls flip me our KMs on EOL care for this morning?

Thanks E

From: tno@gov.bc.ca
Sent: Tuesday, January 12, 2016 7:45 AM
Subject: CBCV: Miller - palliative care

CBCV (CBC Victoria)
CBC On the Island
12-Jan-2016 06:49

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