

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 920630

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

TITLE: Royal Inland Hospital, Kamloops – Master Site Plan

PURPOSE: Minister's Office/Premier's Office request for meeting advice for a meeting with Thompson Regional Hospital District Chair, Peter Milobar, regarding the Royal Inland Hospital (RIH), in Kamloops, Master Site Plan.

Background:

- The Royal Inland Hospital (RIH) is located in Kamloops. The South Tower was constructed in 1965, the East Wing and West Wings were added in 1977, the North Tower in 1980 and the Northwest Wing in 1988.
- RIH is a tertiary referral hospital providing: 24-hour emergency services, including trauma services and advanced diagnostic imaging such as MRI, and other core services such as general surgery, maternity, pediatrics, and laboratory.
- In July 2011, Interior Health Authority (IHA) completed a site master plan to guide the planning of projects at RIH over the next 5, 10 and 15 year horizon. Surgical capacity, inpatient unit expansion, ambulatory care, and site access (parking) are identified as key components of the Master Site Plan.
- Since 2001, over \$80 million in major capital investments were made at the RIH. See Appendix 1 for a listing of capital projects underway and completed.

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Discussion:

- The Master Site Plan is a comprehensive plan that will guide IHA's planning and development of projects at RIH for the next five years (2016/2017), 10 years (2021/2022), and 15 years (2026/2027).
- IHA's top capital priorities include two projects for RIH:
 - A new multi-storey surgical and inpatient tower with below-grade parking with an estimated cost of \$400 million.
 - A separate parking structure with an estimated cost of \$18 million.

Advice:

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Assistant Deputy Minister: Manjit Sidhu

Program Contact (for content): Kevin Brewster, Executive Director, Capital Services Branch

Telephone: 250 952-1102

Drafter: Cathy Slecva, Director, Capital Services Branch

Date: March 9, 2012

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Appendix 1 – Royal Inland Hospital (RIH) Capital Projects

Since 2001, over \$80 million in major capital investments were made at the RIH. The capital projects underway or completed at RIH include:

Projects Underway

- Medical Device Reprocessing (MDR) (central sterilization department) expected to be completed in Summer 2012.
 - \$10.8 million total project cost funded by the Province and RHD.
 - Redesign and expansion of the MDR unit including purchase and installation of new sterilization equipment.
 - New dedicated elevator between the operating rooms and the MDR unit.
 - Renovations to the clean supply holding room and soiled workroom.
 - New case cart system to transport surgical instruments to and from the operating room.
- Upgrades to the RIH heliport are expected to be completed in Summer 2012.
 - \$750,000 total project cost funded by the IHA and RHD.
 - A collaboration of efforts between the City of Kamloops, BC Ambulance Service, and Transport Canada resulted in an interim heliport constructed on vacant City-owned land in December 2011. This temporary heliport will remain in place until the RIH heliport upgrading is completed.

Projects Completed

- Intensive Care Unit (ICU) Renovations (officially opened January 31, 2011, with full project completion in September 2011), \$11.0 million cost – funded by: IHA, RHD and Foundation.
 - Consolidation of two ICU units into one 17-bed ICU unit including five isolation rooms and a bariatric room.
- Second CT Scanner Suite (operational in April 2011), \$3 million – funded by the IHA, Foundation and RHD.
- Emergency Electrical Upgrade (completed in 2010), \$4.1 million – funded by the IHA and RHD.
- New Cancer Clinic (completed in 2009), \$2.4 million – funded by the Foundation.
- Second Floor Redevelopment (completed in 2006), \$27 million – funded by the Province and RHD.
 - Redevelopment and expansion of Emergency and Medical Imaging Departments and fixed MRI that replaced the mobile service.

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff: 923103

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

TITLE: Donation of Used Medical Equipment

PURPOSE: Provide information on the availability of used medical equipment for donation to Nyahururu District Hospital, Republic of Kenya.

BACKGROUND:

The Minister of Health (the Minister) has been solicited to donate surplus medical equipment for the Nyahururu District Hospital in the Republic of Kenya.

The Minister requested Ministry staff to:

1. Approximate how much used and surplus medical equipment being sought by the Kenyan hospital is available in British Columbia (BC) hospitals and;
2. If surplus equipment is available, develop a plan where the BC Government coordinates an effort to transfer the surplus equipment to the Kenyan Ministry of Medical Services.

DISCUSSION:

Used medical equipment typically falls into one of the following categories:

- Diagnostic equipment (e.g., x-ray, CT, MRI);
- Medical devices (e.g., instruments, scopes, implants, monitors, pumps) – items that are attached to a patient; and,
- Furnishings and mobility equipment (e.g., beds, wheelchairs, crutches) – items that are not attachable to a patient.

Used diagnostic equipment is typically taken back by equipment vendors through purchase agreements for new equipment. These vendors either recycle the units or refurbish the units for resale or donation to other areas in the world.

In Canada, used medical devices are regulated by Health Canada. The regulations categorize the devices based on the risk associated with their use. Donation of used medical devices typically requires a license for disposal from Health Canada.

Furnishings and mobility equipment is the most suitable category for donation. Included in this category are items which are not attachable to a patient such as: hospital beds, stretchers, wheel chairs, and crutches.

In November 2010, the Ministry canvassed the HA's for a similar request for medical equipment donation. This canvass determined the following and is applicable for this request:

- A listing of surplus items is not available given the short time frame;
- Compiling a list would take significant time, as surplus equipment is managed facility-by-facility -- not centrally (HA-wide);
- Many surplus items are retained by facilities for spare parts;
- Vendors often take back old equipment on trade; and,
- Items not retained or traded in, providing the items are still safe and still have useable life, are often donated to local organizations (e.g., Veterans groups), educational institutions, or to groups such as the Compassionate Resource Warehouse (<http://www.crwarehouse.ca/>) for subsequent donation outside of Canada.

ADVICE:

S. 13, S. 17, S 16

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MINISTRY OF MEDICAL SERVICES
REPUBLIC OF KENYA



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ICT MEDICAL SERVICES OFFICER
NDARUA NORTH/SOUTH DISTRICT

P.O. BOX 86
NYAHURURU

PROPOSAL TO SOLICIT FOR MEDICAL EQUIPMENTS

FOR

NYAHURURU DISTRICT HOSPITAL

Submitted to:
Mr George Imbenzi
Honorary Consul General
Republic of Kenya
British Columbia, CANADA

Date of Submission:

23rd January 2012 via Email: kenyaconsul@rogers.com

Copied to Permanent Secretary ministry of Foreign Affairs, Republic of Kenya
(via Email: PS@mfa.go.ke)

Submitted by

Michael N Mugo, Chairman, Accident and Emergency Unit Steering Committee
+254-726 736 125 Email: mugomichael@ymail.com

On Behalf of:

Dr Lawrence Kamando, District Medical Services Officer,

Medical Superintendent for Nyahururu District Hospital

INTRODUCTION AND BACKGROUND

Nyahururu District Hospital is geographically in Laikipia District but in Healthcare delivery is classified to serve Nyandarua North District population with a catchment population of 180,000 people. The location of the hospital in intersection between Nyahururu-Nyeri and Maralal-Gilgil makes it an important health delivery centre, especially in Accident and Emergency care.

It lies between latitude 0° 08 N and 0° 50 S and between longitude 35° 13 EAST and 36° 42 EAST.

The altitude varies between 399 meters above sea level on the aberdare ranges to the south east and 1828 meters towards the floor of the great Rift Valley. Water supply is from Lake Olbolosat that is fresh water lake from which River Ewaso Nyiro forms the famous Thomson's falls. It's neighboring Districts are Laikipia to the North, Nyeri and Muranga to the East, Nakuru to the West and Kiambu to the South. The main social economic activity of the catchment population is farming (peasant farmers).

Nyahururu hospital started as a dispensary in 1928 by the British government with five building i.e the current Administrative block, current female surgical ward and female medical, the current VCT room as a mortuary. On 9th February 1968, the Kenya government upgraded it to a District Hospital.

Maternity Ward, Pediatrics Ward also known as Harambee Ward, Male Medical Ward was built in 1996, EJAF Block (1999) which serves as HIV/AIDS Comprehensive Care Centre and Hospice. A modern Operating Theatre was built in 2007. Construction of a Casualty Block was started in 2010 and is ongoing with the structural works complete and remaining with finishing works and installation of equipments.

Development in terms of infrastructure has been slow despite the rapid increase in the catchment population.

VISION

To be an efficient Cost-effective medical care system for a healthy nation for all Kenyans

Mission

To promote and participate in the provision of integrated and high quality and rehabilitative services which are equitable, accessible, affordable, available and acceptable to all Kenyans

Mandate

The hospital is a level four facility which offers promotive, preventive, curative and rehabilitative services. It is a primary referral hospital for level 2 (Dispensary) and 3 (Health Centre) facilities within Nyandarua and Laikipia Counties targeting catchment population of approximately 180,000 people. It also offers clinical services, specialized laboratory and radiological services for level 2 and 3 facilities in its catchment area and other Districts like Laikipia West, Nakuru North, Baringo and Nyeri. The hospital is therefore over utilized and requires urgent expansion to meet the demand of the population. The hospital offers in-patient services for all cohorts. The services offered are maternity services, surgical, medical, gynaecology and paediatric. Out-patient services offered are ANC, Family planning, immunizations, Integrated Management of Childhood Illnesses (IMCI), HIV/AIDS Provider Initiated Testing and Counseling PMTCT, Growth monitoring, Psychiatric, Eye, ENT, Tuberculosis Clinic, Routine and Specialized laboratory services, X-ray, Ultrasound scanning, orthopaedic clinic, physio and occupational therapy, dental, HIV/AIDS Provider Initiated Testing and Counseling (PITC), Voluntary Counseling and Testing, Hospice, and mortuary services.

The hospital has a bed capacity of 142 beds and 27 cots. It has a bed occupancy rate of above 100% and average daily occupancy of 150 and average daily outpatient attendance is 600 people.

PURPOSE OF THE PROPOSAL

The proposal is geared towards achievement of National Health Sector Plans, Ministerial Strategic Plan and is in line with Kenya Vision 2030 whose objective is to make Kenya a Middle Income Earner by the year 2030. It is to support National Health Sector Strategic Plan II goal of reducing health inequalities and reversing the declines in the key health indicators by provision of modern equipment to improve health outcomes of delivery of quality health care to our client and to improve quality of life of population of Nyandarua and Laikipia Counties.

OVERALL GOAL

To produce and improve the health status of all Kenyans through deliberate restructuring of the health sector to make all health services more effective, accessible and affordable.

SPECIFIC OBJECTIVES

1. To improve accuracy of diagnosis for appropriate intervention measures.
2. Improve quality of care and management of our client.
3. Minimize referral out cases to cut on cost for our client and the institution.
4. Improve institutional capacity through provision of modern medical equipment for immediate response to save life.
5. Reduce mortality rate by 10% through timely interventions.
6. Build capacity of health workers for appropriate case management through exposure and use of modern diagnostic medical equipment.

PROJECT JUSTIFICATION

Provision of quality health care is a key to the social pillars of vision 2030. To achieve millennium development goal it is mandatory to equip our facility with modern medical

equipment to enhance quality care.

The nearest critical care services in public hospitals are currently available at Rift Valley PGH Nakuru which is 60km away, PGH Nyeri 100km and Kenyatta National Hospital 180km hence, makes it indispensable to strengthen the capacity of the facility to be equipped with diagnostic medical equipments and well equipped critical care equipments to ensure no life is lost. Many lives have been lost which would otherwise be saved due long distance to referral facility to seek critical care and life support service.

The facility has daily outpatient attendance of 600 patients and has a bed occupancy rate of 100%. This is an indicator that the hospital is overwhelmed with high workload hence indicate positive health seeking behavior of the target beneficiaries. Based on this it is the mandate of health sector and other stakeholder to ensure accessibility of quality service by embracing modern techniques and technology to improve case management.

The few equipments available at the hospital are obsolete and difficult to get spare parts to enhance sustainability of services, this have comprised quality of care at the facility leading to high mortality rate especially the pregnant, lactating and children under 5 years who are the most vulnerable groups.

Funding from exchequer is very erratic and inadequate to facilitate procurement of modern medical equipments. Currently the hospital receives a quarterly allocation of 1.6 million which is not adequate even to facilitate payment of monthly utility bill of the hospital. The hospital currently is sustained by revenues which are accrued from cost-sharing which is only enough to facilitate recurrent budgets. The supplier from Kenya Medical Supplies unit is very irregular in terms of commodity and equipment supplies. High poverty level, recurrent unpredictable inflationary condition is greatly affecting community's contribution towards provision of quality in terms of cost sharing.

Based on this we would kindly seek for your esteemed organization to make impact intervention in provision of equipments to our facility to facilitate the provision of accessible, affordable quality services to improve health outcome.

EQUIPMENTS REQUIRED FOR THE PROPOSED ACCIDENT AND EMERGENCY UNIT

ITEM

NO.REQUIRED

TRIAGE AREA

1. Patient stretcher and Trolleys

15

RESUCITATION ROOMS

1. Defibrillators	-	3
2. Emergency trolleys	-	5

X-RAY

1. X-ray machine	-	1
2. Portable x-ray machine	-	1
3. Ultrasound machine	-	1
4. CT-Scan machine	-	1

OPERATION ROOM

1. Anaesthetic machine	-	2
2. Ventilators	-	2
3. Patient monitor	-	2
4. Theatre table	-	2
5. Orthopaedic/Traction table	-	2
6. Diathermy machine	-	2
7. Theatre stretchers	-	10
8. Sterilizing machine	-	2
9. Step stools	-	2
10. Anaesthetic trolleys	-	5
11. Emergency trolleys	-	10
12. Basic instruments trolleys	-	10
13. Mayo's trolleys curved	-	10
14. Mayo's trolleys	-	10
15. Linen trolleys	-	10
16. Instruments sets		

-	Traumatology set	-	5
	-Laparatomy sets		
	- (adult)	-	5
	- (peadiatric)	-	5
-	General orthopaedic sets	-	5
-	Plating set		
	(small fragment)	-	5
	(large fragment)	-	5
-	Craniotomy set	-	5
-	Interlocking nail sets	-	5
17.	Theatre clogs	-	20 pairs
18.	Theatre gowns	-	50
19.	Theatre lights		

RECOVERY ROOM

1.	Two part theatre stretchers	-	5
2.	Patient monitors	-	5

INTENSIVE CARE UNIT (I.C.U)

1.	I.C.U beds	-	10
2.	Patient monitors	-	10
3.	Ventilators	-	10
4.	Nursing trolleys	-	20
5.	Medicine trolleys	-	20
6.	Ward screens	-	20
7.	Bed side cabinets	-	20
8.	Suction machine	-	10

I.C.U LAB

1. Blood gases machine	-	2
2. Electrolyte Analyzer	-	2
3. Hematological analyser	-	2
4. Elisa machine	-	1

HIGH DEPENDENCY UNIT (HDU)

1. HDU beds	-	10
2. Patient monitor	-	10
3. Bedside overside tables	-	10
4. Ward screens	-	20

TRAUMA WARDS

1. Basic manual hospital beds with side rails	-	150
2. Children beds	-	100
3. Delivery bed	-	10
4. Suction machines 20 litres/min	-	10
5. Medical treatment/dressing trolleys	-	20
6. Linen trolley/nursing care	-	10

DENTAL

1. Curing machine (Dry heat)	-	1
2. Dental flasks	-	8
3. Bench press	-	1
4. Semi-adjustable articulator	-	3
5. Hinge articulators	-	3
6. Spirit lamps	-	3
7. Dewaxing tongs	-	2

8. Plaster knives	-	3
9. Lacron kit	-	1
10. Dental clamps for 2 flasks	-	4
11. Curing machine (wet)	-	2
12. Pressure partial denture cooker	-	2
13. Slow speed motor with hand pieces	-	2
14. Suction machine	-	2
15. Assorted conservation instruments	-	2 sets
16. Assorted periodontal instruments	-	2 sets
17. Dental chair	-	1

PHYSIOTHERAPY DEPARTMENT

1. Short wave diathermy (SWD) machine		
2. Cervical traction kit (Saunders)		
3. Tens		
- Bio med plus		
- Tens med 931		
- Tens med 911		
4. Tens cables for (i) Bio med plus	-	4 pairs
(ii) Ten med 931	-	4 pairs
5. Tens rubber electrodes		
(i) Large	-	4 pairs
(ii) Small	-	4 pairs
6. Hydro pack steam pad plus pack heater		
7. Ice packs and a chilling unit		
8. Bio gear (static cycle)	-	2
9. Chest expanders	-	4
10. Assorted hand grip exercisers		

11. Therapeutic putty	-	2kg
12. Gyro exerciser and springs		
13. Exercise mats	-	6
14. Heavy duty orthopaedic cord	-	1 roll
15. Bmdomed- 182	-	1
16. Electric complete intermittent beds	-	2
17. Ultra sound contact gel	-	
18. Rowing machine	-	2
19. Ultrasound and stimulating currents machine – leads (cables)		

OTHERS

1. Hemodialysis machines	-	10
2. Stethoscopes	-	20
3. Wheel chairs	-	20
4. Digital thermometers	-	50
5. Blood pressure machines	-	30
6. X-ray views	-	20
7. Lab bench	-	2
8. Incubators	-	20
9. Bedside lockers		

EXPECTED IMPACTS

1. Patients chances of survival is greatly improved if the patient receives definitive treatment and care.
2. Reduce morbidity and mortality to realize millennium development goals.
3. Expected to reduce waiting time from current 3 hours to 1 1/2 hours.
4. Reduce cost of referral out both for victims and the facility.
5. Empower skill of staffs in appropriate case management through use of modern medical equipment.
6. Increased staff motivation and build self esteem which will enhance good relationship and improve outputs.

7. Improved quality of life which leads to improve living standards of people and stimulate economic growth.

CONCLUSION

For us to forge forward in achievement of vision 2030 it is critical to partner with all other stakeholder to mobilize for resources to equip our facility with modern medical equipment to offer the highest attainable standard of health service.

Based on this I would kindly request your organization to donate for us the above listed medical equipments.

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff: 924177

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

TITLE: Vancouver General Hospital (VGH) - New Mental Health Pavilion Project

PURPOSE: Project status information for a meeting with major donors Joe and Rosalie Segal on April 5, 2012.

BACKGROUND:

- Currently, inpatient mental health services at VGH are housed in the Health Centre (Circa 1943), a building at the end of its life expectancy that no longer meets the facility requirements for best practices in health care delivery.
- The proposed Mental Health Pavilion Project will provide a new, purpose built facility on a green field site on the VGH campus adjacent to the Banfield Pavilion.
- The replacement ranks as the highest priority on Vancouver Coastal Health Authority's (VCHA) major capital project priority list.
- The new 100-bed facility will consolidate all mental health inpatient and outpatient services at VGH and the University of British Columbia Hospital (UBCH) including:
 - 60 beds from the Health Centre
 - 20 beds from Centennial Pavilion
 - 20 beds from UBCH
- VCHA advises that no additional psychiatric inpatient capacity is required. There are sufficient beds to serve Vancouver through 2030.
- The new building will also include the Psychiatric Assessment Unit (relocated from Jim Pattison North) providing short-term inpatient crisis intervention services.
- The capital cost for the Mental Health Pavilion Project is estimated at \$73 million.
- Of this amount, \$25 million is already committed through the VGH and UBC Hospitals Foundation (the Foundation), and its corporate and private donors. A generous donation of \$12 million from Joe and Rosalie Segal will go toward establishing the new Mental Health Pavilion.
- Provincial capital funding of \$48 million is required to fully fund the project.

DISCUSSION:

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- The project is expected to take approximately three years to design and construct from approval of the business case.
- Government Communications and Public Engagement are working with the Premier's Office and VCHA to find the earliest possible date for an announcement that fits the calendars of both Premier Christy Clark and Joe and Rosalie Segal.
- The announcement will indicate that planning is underway and acknowledge the generous donation from Joe and Rosalie Segal, who will be invited to participate in the announcement event.
- During the announcement event, it is expected that a large infrastructure sign will be unveiled. The sign will include logos of the province, VCHA and the Foundation.
- It is expected that once project approval is granted, VCHA will submit a request to government to name the new VGH Mental Health Pavilion after Joe and Rosalie Segal.

ADVICE:

S. 13, S. 17

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 VGH -New Mental Health Pavilion Project.doc

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff: 927368

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

TITLE: BC Cancer Agency (BCCA) Foundation Jambor-McCarthy Legacy
and Provincial Matching Funds

PURPOSE: Provide information on why provincial matching funds (capital
funding) cannot be provided directly to the BCCA Foundation.

BACKGROUND:

- The Foundation is the fundraising partner of the BCCA.
- Minister de Jong met with foundation representatives February 13, 2012.
Also attending were Jess Ketchum – Director and Board Chair (Volunteer),
Greg D'Avignon – Director and Chair, Development Committee (Volunteer) and
Doug Nelson – President and CEO.
- The Foundation proposed that the province match the \$21.4 M Jambor/McCarthy
legacy gift by funding further replacement and expansion of radiation therapy
equipment. The legacy will be used for a permanent research endowment, a new
research chair and support for cancer care in Burnaby as per the terms of the gift.
The legacy gift funds cannot be used to support the radiation equipment replacement.
- In 2010/11, the Foundation raised \$39.2 M through individual philanthropy and
charitable events, less \$10.2 M in direct fundraising costs, resulting in net fundraising
revenue of \$29.0 M. The Foundation provided \$18.6 M to support the BCCA and as
of March 31, 2011, the Foundation held net assets of \$60.1 M¹

DISCUSSION:

- The Ministry of Health (the Ministry) supports planned replacement and expansion of
radiation therapy equipment.
- BCCA developed a rolling ten year plan to address both the replacement of aging
radiation therapy equipment and to acquire additional equipment to address increased
demand. The total cost of the plan is estimated at \$85 M.

¹ BC Cancer Foundation 2010/11 Audited Financial Statements (June 2011) www.bccancerfoundation.com

- Since 2008/09 the Ministry approved \$60 M in capital funding for replacement and expansion radiation therapy equipment as follows:
 - \$48 M for the replacement of four existing Linear Accelerators (Linacs), and the addition of one Linac and a brachytherapy room at the Cancer Centre of the Southern Interior (CCSI) in Kelowna (completed Fall 2011); and, four replacement Linacs at the Vancouver Cancer Centre (VCC) (completed January 2011); and,
 - \$12 M for the first phase of radiation therapy equipment replacement at the BCCA Vancouver Island Centre (VIC), and installation of an additional brachytherapy room. Project completion is planned for 2013. Work is underway however this project has not been formally announced to date.

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927606

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

TITLE: Royal Inland Hospital (RIH) in Kamloops – Master Site Plan

PURPOSE: To inform the Minister on future capital development plans for RIH for meetings with the Honourable Terry Lake, MLA, and Kevin Krueger, MLA and; a subsequent meeting with His Worship Peter Milobar, Mayor of Kamloops.

BACKGROUND:

The RIH in Kamloops is a tertiary referral hospital providing 24 hour emergency health services including trauma care, general surgery, maternity, paediatrics, laboratory, and advanced diagnostic imaging (CT and MRI scanning). The RIH is situated within the Thompson Cariboo Shuswap Health Service Area and is one of two tertiary referral hospitals (the other is Kelowna General Hospital) within the Interior Health Authority (IHA).

The RIH campus was originally constructed in 1965 with additions in 1977 (East and West wings), 1980 (North tower) and in 1988 (Northwest wing). Since 2001, over \$80 million in major capital investments have been made at the facility. Capital projects currently underway at RIH include:

- Medical device reprocessing (central sterilization) unit - \$10.8 million; and
- Upgrading to the RIH heliport - \$750,000.

Collaboration between the City of Kamloops, the BC Ambulance Service, and Transport Canada resulted in an interim heliport constructed on vacant City-owned land in December 2011. This temporary heliport will remain in place until the RIH heliport upgrading is completed.

In July 2011, the IHA completed a master site plan to guide the planning of capital projects at RIH over the next 5, 10 and 15 year horizons. Surgical capacity, inpatient unit expansion, ambulatory care, and site access (parking) are identified as key components of the master site plan. A confidential summary of the master site plan outcome is attached as Appendix One.

The RIH master site plan envisions a phased renovation and redevelopment of the hospital to include the following expansions over a 15 year period:

- Phase 1 - service building and parkade off Columbia Street;
- Phase 2 – new surgical tower; and,
- Phase 3 - new inpatient tower.

Capital funding for projects at RIH is typically cost-shared by the Province and the Thompson Regional Hospital District.

DISCUSSION:

It is common for hospital sites to have master plans to guide capital planning and prioritization at the hospital site and across the health authority. The IHA has undertaken consultation with hospital staff, public and the regional hospital district regarding the future development planning at RIH. The IHA has identified severe site access constraints (a deficit of parking) to be their highest capital priority at RIH.

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ADVICE:

S. 13, S. 17

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

CHff # 925799

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

TITLE: Status of Proposed Intensive Care Unit (ICU) Expansion Project, East Kootenay Regional Hospital (EKRH), in Cranbrook

PURPOSE: Background information for a meeting with Minister Falcon and MLA Bill Bennett on April 19, 2012.

BACKGROUND:

- Interior Health Authority (IHA) has identified an expansion to the ICU at the EKRH as a high priority in their capital plan.
- The proposed project includes:
 - relocation of the ICU unit to be in closer proximity to the Emergency and Diagnostic Imaging departments,
 - expansion of the ICU from a 4 bed unit to a 6 bed unit, and
 - larger and redesigned space to meet current standards of care.
- The estimated capital project cost for the ICU Expansion is approximately \$11 million and is subject to available funding. Incremental annual operating costs are estimated at \$1.059 million.
- IHA advised that since their capital plan was developed, they have determined:
 - The electrical systems in the hospital need to be replaced or upgraded prior to any expansion in the facility for an estimated cost of \$6 – \$7 million. IHA is preparing a separate project business case for this work.
 - Expansion of renal services at EKRH is required. Planning is underway to determine the scope and estimated cost for this work.
- As of April 2011 no capital funding has been allocated to this project in the Ministry of Health's (Ministry) capital plan.
- Once the Ministry receives its 2012/13 capital budget letter, the health authorities will receive a provincial capital funding allocation which they will combine with other available funding sources.
- Health authorities will be requested to submit a listing of priority projects to the Ministry to identify projects that are affordable within their available funding. Business cases for projects, such as the EKRH ICU Expansion, require Ministry review and approval prior to proceeding to procurement.
- IHA advises that the Kootenay East Regional Hospital district, the EK Foundation for Health and the Cranbrook Healthcare Auxiliary have expressed interest in this project.

1 of 2

- It is unknown at this time what IHA's 2012/13 provincial capital allocation will be, and whether the proposed projects for EKRH are affordable.

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Telephone: 250 952-2066

Program Contact (for content): Kevin Brewster, Executive Director, Capital Services Branch

Drafter: Cathy Sleeva, Director, Capital Services Branch

Date: April 17, 2012

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BN.docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

Cliff # 918742

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

TITLE: *Ministry of Health 2012/13 – 2014/15 Service Plan*

PURPOSE: Obtain final approval of the *Ministry of Health 2012/13 – 2014/15 Service Plan*

DISCUSSION:

The Ministry's *2012/13 – 2014/15 Service Plan*, required under the *Budget Transparency and Accountability Act*, will be tabled and published with the provincial budget on February 21, 2012. Final approval of the service plan is required by February 13, 2012.

The service plan is intended to provide the public a high level overview of the Ministry's strategic direction. The document clearly identifies and communicates the objectives of the Ministry, the results the Ministry expects to achieve and resources the Ministry employs.

The attached version of the service plan has been prepared in compliance with the guidelines and prescribed template provided by Cabinet Operations and has been through standard review procedures, including review and approval by Ministry Executive, Government Communications and Public Engagement and Treasury Board Staff.

ADVICE:

With the Minister's approval, the service plan will be submitted to Cabinet Operations on February 14, 2012 and proceed to tabling with the provincial budget on February 21, 2012.

Please contact Nick Grant if any changes to the service plan are required.

Program ADM/Division: Elaine McKnight, ADM, Planning and Innovation Division
Telephone: 250-952-2563

Program Contact (for content): Nick Grant, Executive Director, Strategic Management Branch

Drafter: Brooke Somers, Research Officer, Strategic Management Branch

Date: February 9, 2012

File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\918742 - BN
Ministry of Health 2012-13 to 2014-15 Service Plan.docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 919949

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

TITLE: Launching ThinkHealthBC

PURPOSE: To facilitate discussion and provide context around the options for launching ThinkHealthBC prior to supporting advertising

BACKGROUND:

The Ministry of Health (the Ministry) is preparing to publically launch a significant citizen engagement and health education initiative called ThinkHealthBC. The purpose behind ThinkHealthBC is to provide context around the Ministry's long term health care plan and strategy, as well as to create a platform for citizen engagement and discussion around these elements.

These objectives will be delivered through a series of unique and educational videos and an online forum for dialogue, which will be moderated 7 days a week. The Ministry has been preparing for an early March launch, however that timeframe has been somewhat compromised due to pending by-elections which, once underway, will impact the initiative's ability to utilize paid advertising to spread awareness of the project.

DISCUSSION:

Ministry staff and project consultants believe that continuing to plan for the March 2, 2012, launch, without the media campaign starting simultaneously, may actually be a positive outcome for the overall initiative and should be seriously considered. This would create an approach which ramps up various communications activities in a more phased approach and is expected to have a number of key benefits.

Leveraging the lessons learned from the BC Education Plan (which had no paid advertising until recently) having a soft launch allowed for their Ministry to work out the operational complexities of supporting online dialogue. Having the ability to limit the initial site volume will allow us to enhance the operational capabilities of the Ministry moderating staff - and allow us to make changes/improvements to the site prior to heavier traffic periods.

Secondly, by utilizing, this lower traffic period effectively, Ministry staff will be able to collect and populate interesting and relevant conversations as content on the site. This will translate to a richer overall site experience for the extended audience once full traditional media resources are engaged – building reputation and word of mouth for the new Thinkhealthbc.ca brand.

ADVICE:

In light of the aforementioned points we recommend the following:

1. Launch the site on March 2, 2012, at the WOSK Centre as planned, with a focus on getting a strong health student audience along with social media advocates, patients and the media – these are the groups that will help to propel this initiative and create a base of support.
2. Build the agenda for that event to garner the greatest amount of interest and follow up with advocates and media. Highlight as much site content as possible to demonstrate breadth of content - and to stimulate subsequent media and consumer interest and response.
3. Work with GCPE to find ways to provide an accessible and useful package of the ThinkHealthBC creative materials ('Best of reel' – various video content including TV spots and highlights of educational and stakeholder videos.) for either pre- or post-event distribution to the media. Utilize GCPE expertise to determine the broadest outreach strategies against extended audiences with launch/press release materials, including cross pollination opportunities with other government engagement sites.
4. Continue to work with GCPE to determine the potential for using any number of alternative or cumulative tactical initiatives to ramp up the awareness around the ThinkHealthBC launch. This will include considerations around paid advertising in allowable geographical markets not impacted by the media restrictions of the by-election timing, as well as assessing opportunities around collateral/point of sale (medical venue) strategies.
5. Continue to work on an aggressive outreach plan for earned media, both in regards to the March event launch and subsequent points of interest (new content coming on line - post initial launch etc.).
6. Similarly, with regards to social media - aim to push content to high profile bloggers and extended stakeholder partners, and in turn, post on the site initial feedback and perceptions on all the various elements of the site, again building site content and validity. This will signal immediately to all stakeholders that we are listening.
7. Remain focused on a media plan to buy in all planned markets at the earliest time allowed post bi-election black out.
8. Utilize the relatively slower traffic period (post launch) to ensure that any operationally challenges are worked through prior to the wider public launch and, to collect a greater comment/discussion base, making experience on the site more engaging.

Program ADM/Division: Christine Massey, Planning and Innovation Division

Telephone: 952-2563

Program Contact (for content): Nikki Sieben, Executive Director, 952-1170

Drafter: Nikki Sieben

Date: February 20, 2012

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Launching ThinkHealthBC.docx

**MINISTRY OF HEALTH
DECISION BRIEFING DOCUMENT**

Cliff # 925148

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

TITLE: World Elder Abuse Awareness Day

PURPOSE: To seek approval of the Minister's message in recognition of
World Elder Abuse Awareness Day on June 15, 2012

BACKGROUND:

The International Network for the Prevention of Elder Abuse (INPEA) launched World Elder Abuse Awareness Day (WEAAD) on June 15, 2006. Each year since 2006, British Columbia has joined the United Nations, the World Health Organization, the Federal Government of Canada and other jurisdictions around the world in recognizing WEAAD.

In past years, BC has proclaimed June 15th as WEAAD, issued a Minister's message, distributed WEAAD materials to stakeholders and posted information on the Ministry's website. In 2010 and 2011, the Safety and Security Working Group of the Federal/Provincial/Territorial (FPT) Ministers Responsible for Seniors produced materials for distribution on financial planning and protection in order to avoid financial abuse (Fact Sheets). This year, the Fact Sheets will again be available for downloading from the SeniorsBC.ca website.

DISCUSSION:

Recognition of WEAAD is consistent with the commitment in *Healthy Minds, Healthy People: Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*, released in 2010, to "implement a coordinated provincial initiative to prevent elder abuse so that seniors will be less vulnerable to emotional, psychological and physical abuse."

The Ministry of Health is currently engaged in province-wide consultation processes to inform the development of an office of the Seniors' Advocate and an elder abuse prevention, identification and response strategy, as called for in *Improving Care for B.C. Seniors: An Action Plan* (released February 14, 2012).

The Proclamation for WEAAD 2012 (attached as Appendix I) has already been prepared and signed. In addition, it is proposed that BC once again recognize WEAAD by posting the Minister's message (attached as Appendix II), which refers to the Fact Sheets, on SeniorsBC.ca.

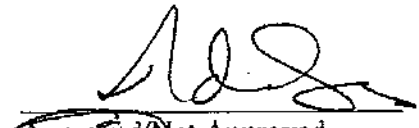
OPTIONS:

1. Approve the Minister's message in recognition of World Elder Abuse Awareness Day on June 15, 2012. Recognition would support the Government's commitment to reduce the prevalence of elder abuse in the province, and leverage efforts to disseminate materials on financial abuse.
2. Do not approve the Minister's message in recognition of World Elder Abuse Awareness Day on June 15, 2012.

FINANCIAL IMPLICATIONS:

There are no direct costs associated with the recognition of WEAAD.

RECOMMENDATION: OPTION #1


Approved/Not Approved
Honourable Michael de Jong
Minister

May 30, 2012
Date Signed

Program ADM/Division: Heather Davidson, Planning and Innovation Division
Telephone: 250 952-2563
Program Contact (for content): Kelly Acker, 250 953-4513
Drafter: Paige MacWilliam
Date: May 8, 2012
File Name with Path: S:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\P&I\925148 -
Decision BN re World Elder Abuse Awareness Day.docx

World Elder Abuse Awareness Day - June 15, 2012

Message from Honourable Michael de Jong

Minister of Health

The Government of British Columbia has once again recognized June 15th as World Elder Abuse Awareness Day (WEAAD). This year, as in the past seven years, British Columbia will join with jurisdictions around the world in bringing attention to this serious social and public health issue.

Sadly, elder abuse is under-recognized and under-reported. Raising awareness of this often hidden issue is an essential part of putting a stop to elder abuse. WEAAD is an opportunity for individuals, organizations, and communities across the province to promote independence, dignity, and security for all British Columbians as they age.

In February of this year, the Provincial Government released the *Improving Care for B.C. Seniors: An Action Plan* (Action Plan), which identifies the need to protect seniors from abuse and neglect. As part of the Action Plan, the Ministry of Health has engaged with individuals, organizations and communities to provide input into the development of a provincial elder abuse prevention, identification and response strategy, due to be completed this year.

The Ministry of Health works to promote healthy and active aging and independence for all British Columbians, and this includes freedom from abuse of every type. Please visit the "Elder Abuse Prevention" section of the SeniorsBC.ca website for links to a variety of resources, including a series of financial planning and protection fact sheets designed to help seniors guard against financial abuse.

I believe it is time for British Columbians to become more informed about elder abuse and to take action in order to better protect those who are vulnerable. This day is a reminder to each of us that elder abuse adversely affects individuals, families and communities across the province. Please join me in recognizing WEAAD, and the many individuals and organizations devoted to ending abuse.

Honourable Michael de Jong, QC
Minister of Health



Canada
Province of British Columbia
A Proclamation

ELIZABETH THE SECOND, by the Grace of God, of the United Kingdom,
Canada and Her other Realms and Territories, Queen, Head of the
Commonwealth, Defender of the Faith

To all to whom these presents shall come – Greeting

WHEREAS throughout the world, abuse and neglect of older persons is largely under-recognized, and

WHEREAS World Elder Abuse Awareness Day is in support of the United Nations International Plan of Action which recognizes the significance of elder abuse as a social issue, and

WHEREAS a better understanding of abuse and neglect will support the development of awareness into action, and

WHEREAS seniors are a diverse population within a society that supports its members throughout the life continuum, and recognizes individual rights to dignity, respect, autonomy and choice, and

WHEREAS citizens, community organizations and public officials all have vital roles in working together and sharing information on how to prevent and recognize signs of abuse or neglect, and

WHEREAS the Government of British Columbia is committed to ensuring that seniors are valued within safe communities and to supporting their contributions to a vibrant 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 June 15, 2012, shall be known as

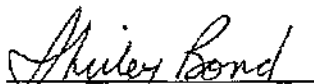
"World Elder Abuse Awareness Day"

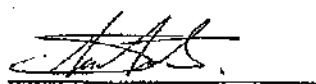
in the Province of British Columbia.

IN TESTIMONY WHEREOF, We have caused these Our Letters to be made Patent and the Great Seal of Our Province of British Columbia to be hereunto affixed.

WITNESS, The Honourable Steven L. Point, Lieutenant Governor of Our Province of British Columbia, in Our City of Victoria, in Our Province, this fourth day of May, two thousand twelve and in the sixty-first year of Our Reign.

BY COMMAND.


Minister of Justice and Attorney General
(consent signature for the Great Seal)


Lieutenant Governor



Canada
Province of British Columbia
A Proclamation

ELIZABETH THE SECOND, by the Grace of God, of the United Kingdom,
Canada and Her other Realms and Territories, Queen, Head of the
Commonwealth, Defender of the Faith

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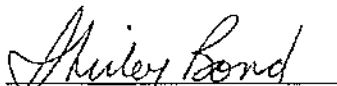
"World Elder Abuse Awareness Day"

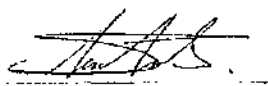
in the Province of British Columbia.

IN TESTIMONY WHEREOF, We have caused these Our Letters to be made Patent and the Great Seal of Our Province of British Columbia to be hereunto affixed.

WITNESS, The Honourable Steven L. Point, Lieutenant Governor of Our Province of British Columbia, in Our City of Victoria, in Our Province, this fourth day of May, two thousand twelve and in the sixty-first year of Our Reign.

BY COMMAND.


Minister of Justice and Attorney General
(counter signature for the Great Seal)


Lieutenant Governor

World Elder Abuse Awareness Day - June 15, 2012

Message from Honourable Michael de Jong

Minister of Health

The Government of British Columbia has once again recognized June 15th as World Elder Abuse Awareness Day (WEAAD). This year, as in the past seven years, British Columbia will join with jurisdictions around the world in bringing attention to this serious social and public health issue.

Sadly, elder abuse is under-recognized and under-reported. Raising awareness of this often hidden issue is an essential part of putting a stop to elder abuse. WEAAD is an opportunity for individuals, organizations, and communities across the province to promote independence, dignity, and security for all British Columbians as they age.

In February of this year, the Provincial Government released the *Improving Care for B.C. Seniors: An Action Plan* (Action Plan), which identifies the need to protect seniors from abuse and neglect. As part of the Action Plan, the Ministry of Health has engaged with individuals, organizations and communities to provide input into the development of a provincial elder abuse prevention, identification and response strategy, due to be completed this year.

The Ministry of Health works to promote healthy and active aging and independence for all British Columbians, and this includes freedom from abuse of every type. Please visit the "Elder Abuse Prevention" section of the SeniorsBC.ca website for links to a variety of resources, including a series of financial planning and protection fact sheets designed to help seniors guard against financial abuse.

I believe it is time for British Columbians to become more informed about elder abuse and to take action in order to better protect those who are vulnerable. This day is a reminder to each of us that elder abuse adversely affects individuals, families and communities across the province. Please join me in recognizing WEAAD, and the many individuals and organizations devoted to ending abuse.

Honourable Michael de Jong, QC
Minister of Health

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927624 / DMA Log # 7 (May)

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

TITLE: Ambulance Services in North Vancouver

PURPOSE: To provide information prior to a Ministry of Health staff meeting with
MLA Thornthwaite on May 16, 2012 at 3:30 p.m.

BACKGROUND:

- Ministry of Health representatives have previously met with the MLA and provided information on North Vancouver ambulance services, as well as government's direction with respect to the integration of fire and ambulance services.
- Some of these discussions have been tied to concerns expressed by S. 22 with respect to ambulance response times in his area.

DISCUSSION:

Fire / Ambulance Service Collaboration

- On February 22, 2012, Minister de Jong met with MLA Thornthwaite to discuss a variety of health system topics, including ambulance services in her area.
- The topic of integrated dispatch was raised and MLA Thornthwaite indicated that North Vancouver Fire Rescue (NVFR) would be extremely interested in participating in such a project. The Minister committed to ensuring that NVFR would be considered for any early pilots of integrated dispatch.
- The Minister's commitment has since been conveyed to the Emergency & Health Services Commission (EHSC), which has legislated authority for pre-hospital emergency care in BC.
- The Ministry continues to support the integration of ambulance and emergency health services more closely with the broader health sector, in order to maintain a provincial approach to these services.
- This approach does not, however, preclude continued collaboration between the EHSC and fire departments with respect to local pre-hospital emergency care.

Constituent Concerns

- S. 22 most recent concerns regarding ambulance response times were managed through the Patient Care Quality Office (PCQO) of Provincial Health Services Authority (PHSA), which also supports the EHSC and ambulance services.
- S. 22 latest care quality complaint has been reviewed and closed by the PCQO.

- Should s. 22 continue to have concerns s. 22 has been invited to follow up with the PHSA PCQO for at 1-855-660-2757 or by email: pcqo@bcas.ca.
- If s. 22 remains unsatisfied with their responses s. 22 can ask to have the matter independently reviewed by the Patient Care Quality Review Board. The Review Board can be contacted by phone at 1-866-952-2448 or by email: contact@patientcarequalityreviewboard.ca.

ADVICE:

The EHSC continues to look at innovative options for service delivery within a provincially coordinated framework that recognizes the most appropriate role of all emergency service providers, including fire departments.

Program ADM/Division: Elaine McKnight, Chief Administrative Officer

Telephone: 250 952-1170

Program Contact (for content): Nikki Sieben, Executive Director, Stakeholder Relations and Transformation

Drafter: Liv Brekke

Date: May 10, 2012

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**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

Cliff #927666

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

TITLE: Telephone call with Rick Hansen on May 9, 2012

PURPOSE: To provide information regarding provincial support for the
Rick Hansen Foundation (Foundation)

BACKGROUND:

In 2009, the Foundation was seeking a funding commitment from the province to coincide with the 25th anniversary of the Man in Motion Tour. Specifically, the Foundation was seeking a total of \$222M over the following seven years, including: \$100M from the province, \$100M from the federal government, and \$22M from corporate and private donors. The launch of the 25th anniversary was held to coincide with the closing of the Paralympic Games on March 21, 2010.

At the Paralympic Games, the Province's contribution of \$25M over seven years was announced, reflecting a new investment of \$11M by the Ministry of Health, combined with the ongoing funding of \$2M per annum from the Ministry of Public Safety and Solicitor General over that same period. This government funding commitment occurred following Ministry of Health consultation with the then Ministries of Education; Housing and Social Development; Advanced Education and Labour Market Development; and Public Safety and Solicitor General. At that time, an inventory of historic, current and possible future government contributions to the Foundation since 2002/03 was developed, totaling more than \$75M (including the most recent \$11M in provincial funding). Additionally, Vancouver Coastal Health Authority currently contributes \$149,000 to the Foundation to support operating costs in the Blusson Pavillion and expects to continue this funding.

The Ministry of Health provided \$5M to the Foundation in March 2010. On March 25, 2011, the Ministry of Health provided \$6M for the Spinal Cord Injury Solutions Network (doing business as the Rick Hansen Institute) to support spinal cord injury services, to develop best practice treatment guidelines and research, and to develop a data registry in British Columbia. These two payments collectively fulfill the Ministry of Health's commitment to provide \$11M in funding as committed.

Program ADM/Division: Heather Davidson, Planning and Innovation Division
Telephone: 952-2563
Program Contact (for content): Elisabeth Wagner, 952-2282
Drafter: Barbara Smith, Victoria Schuckel
Date: May 4, 2012
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**Appendix A – Funding Summary of Government Transfers
to the Rick Hansen Foundation by Ministry**

Ministry/Govt Funded Agency	Historical One-Time Funding	Ongoing Funding	Available Funding
Advanced Education	\$12,800,000		0
Labour Market Development	\$2,250,000		
Ministry of Health Services	\$2,000,000	Treatment and Rehabilitation Services through VCHA \$1,400,000	0
	\$11,000,000		
Vancouver Coastal Health Authority	\$200,000		
Ministry of Housing and Social Development	\$15,000,000 (this funding was accompanied by a challenge to other jurisdictions that resulted in another \$57M including the federal government)	\$100,000 (3 year contract with the BC Paraplegic Association for employment services)	0
	\$500,000 To the BC Paraplegic Association		
Ministry of Education	2,500,000		0
	500,000		
Ministry of Public Safety and Solicitor General		2,000,000 (\$23,500,000 to date)	0
Michael Smith Foundation for Health Research	4,900,000		0
	\$51,450,000	\$25,000,000	
Total:			\$76,450,000 + ongoing funding for treatment and rehab through VCHA

Appendix B- Government funding to the Rick Hansen Foundation by Year

YEAR	MINISTRY	AMOUNT	TYPE of FUNDING	PURPOSE
2002-2003	ALMD	\$12,800,000	Capital matching award	BC Knowledge Development Fund to ICORD for the Blusson Pavilion - funds flowed to UBC. The year the award was announced in 2002/03 – the capital funding would have actually flowed out in later years and over a few years.
2002-2003	ALMD	\$2,250,000	One-time grant	Leading Edge Endowment Foundation Chair for the Rick Hansen BC Leadership Chair in Spinal Cord Research -- funds flowed to UBC.
2003-2004	MoHS	\$2,000,000	One-time grant	To facilitate and support spinal cord injury research - specifically, to support projects and leadership of researchers and clinicians and for strategic planning in the spinal cord injury field
2005-2006	MHSD	\$15,000,000	One-time grant	In recognition of the 20th anniversary of the Man in Motion World tour, directed toward the RHF's 2006-2010 Spinal Cord Injury Strategy, which included \$4 million to the BC Paraplegic Association (\$1 million per year (2006)), \$4 million to ICORD and other non-governmental organizations, and \$7 million for the Foundation to continue its leadership through 2012, support of SCI Solutions Network, quality of life initiative and leverage new funds nationally
2005-2006	MED	\$500,000	One-time grant	To support the Rick Hansen school program
2006-2007	MED	\$2,500,000	One-time grant	To be used for a granting program for accessible play spaces for preschool-aged children with disabilities and their families.
2007-2008	MHSD	\$500,000	One-time grant	To assist BC Paraplegic Association transform its operations
2008-2010	Vancouver Coastal Health Authority	\$200,000	One-time grant over two fiscal years	To support operating costs in the Blusson Pavillion

2010-2011	MoH	\$11,000,000	One-time grant over two fiscal years	To support the Spinal Cord Injury Solutions Network (DBA the Rick Hansen Institute)
2001-2010	Michael Smith Foundation for Health Research	\$4,900,000	Various personnel and career awards	To attract and retain researchers working in the area of spinal cord injury and repair.
TOTAL ONE -TIME		\$51,450,000		
CURRENT/ Ongoing				
Ongoing	SG	\$2,000,000		Created in 1997 to commemorate the 10th anniversary of the Man in Motion tour, the <i>BC Neurotrauma Contribution Act</i> , on or before the end of each fiscal year after March 31, 1998, requires the AG pay to the BC Trauma Fund (i.e., RHF), out the Victim Surcharge Special Account continued under section 9 of the <i>Victims of Crime Act</i> , a grant in an amount that is the lesser of the following: a) \$2million; b) 20% of the money paid to govt that fiscal year under section 8.1 of the <i>Victims of Crime Act</i> . By March 31, 2011 <i>this represents a contribution of \$23.5M to date (02/03 and 03/04 were lesser amounts due to income into the account)</i>
Three year contract – may be extended	MHSD	\$100,000		Three year contract with the BC Paraplegic Association for employment training
Ongoing	MoHS		Vancouver Coastal Health Authority budget	Spinal cord injury treatment and rehabilitation services.VCH provides an array of services and supports for/related to individuals with spinal cord injuries, including: diagnosis, treatment (surgical, secondary, tertiary, trauma), rehab, housing, HCC supports; and highly specialized interventions, e.g., spinal micro-surgery.
TOTAL ANNUAL ONGOING:		\$2,100,000 + VCHA funding for tx services (Funding for RHF from SG is \$23.5M to date)		

Appendix C – Analysis of Three Research Foundation Expenditures in BC – Source Canada Revenue Agency

2009	Rick Hansen Foundation	Terry Fox Foundation	BC Cancer Foundation
Number of permanent, full-time, compensated positions.	63	27	43
Ten highest compensated, permanent, full-time positions			
\$350,000 and over	1		
\$300,000 - \$349,999			
\$250,000 - \$299,999	1		1
\$200,000 - \$249,999	1		1
\$160,000 - \$199,999	4		
\$120,000 - \$159,999	3		3
\$80,000 - \$119,999		2	5
\$40,000 - \$79,999		8	
Number of part-time or part-year employees the charity employed	16	20	3
Total expenditure on compensation for part-time or part-year employees	\$250,643	\$244,183	\$182,988
Total expenditure on all compensation	\$6,284,947	\$1,854,374	\$4,078,964
Total expenditures on management and administration	\$5,131,020	\$750,993	\$2,428,308
Total expenditure on compensation, management and administration	\$11,415,967	\$2,605,367	\$6,507,272
Total expenditures	\$ 22,116,257	\$15,837,122	\$ 30,366,030
% of total expenditures on compensation	28.42%	11.71%	13.43%

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 909885

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

TITLE: Ondine Biomedical Inc. - January 16, 2012 Meeting

PURPOSE: Provide background information for a scheduled meeting with Carolyn Cross, CEO of Ondine Biomedical Inc., and others.

BACKGROUND:

Formerly a public company listed on the Toronto Stock Exchange (TSX) and the AIM market of the London Stock Exchange, Ondine Biomedical Inc. ("Ondine") was acquired on September 6, 2011, by a private company owned solely by Carolyn Cross. Ondine is headquartered in Vancouver, Canada, with a research and development facility in Bothell, Washington, USA and an international office in St. Michael, Barbados.

Ondine is focused on developing non-antibiotic therapeutics for the treatment of a broad spectrum of bacterial, fungal and viral infections, primarily for the healthcare-associated infection market. Ondine's platform technology uses patented light-activated technology called Photodisinfection. Ondine's lead product is the MRSAid™ nasal decolonization system which is used to remove methicillin-resistant *Staphylococcus aureus* (MRSA) from the nares.

Carolyn Cross, Chief Executive Officer of Ondine has requested a meeting to make a presentation on how photodynamic therapy (PDT) can generate better patient outcomes while reducing costs to improve the Province's budgets. Ondine will provide the Minister with a binder of information with Ondine's proposal, including recommendations, costs, and research on the utilization of PDT in other countries. Once received, Pharmaceutical Services Division staff can assist with review and analysis of the materials.

Ms. Cross will be accompanied by Dr Merrill Biel, Professor in the Department of Otolaryngology-Head and Neck Surgery at the University of Minnesota, and the Chancellor, Head and Neck Optical Diagnostics Society in London, England. Dr. Biel is a founder of Advanced Photodynamic Technologies, which was acquired by Ondine Biomedical in 2009.

Also, in attendance at the meeting will be: Peter Geimer, Director, National Sales & Marketing, Ondine Biomedical Inc.; Dr. Coreen Dyck, M.D., RCPSC - General Surgery; Gerri Charles, Chair, Crystal Gala Foundation and Owner, Champagne & Lace; Brittany Manulak, Committee Member, Crystal Gala Foundation and Principal, Concept Plumbing & Gas Ltd.; and Barbara Mowat, President, Impact Communications Ltd.

Dr. Elizabeth Bryce, Regional Medical Director for Infection Control at Vancouver Coastal Health, will be attending the meeting by telephone. Dr. Bryce is dually qualified in Medical Microbiology and Internal Medicine and is a Clinical Professor at the University of British Columbia.

DISCUSSION:

S. 13, S. 17, S. 21

ADVICE:

S. 13

Program ADM/Division: Bob Nakagawa, Pharmaceutical Services Division
Telephone: (250) 952-1705
Program Contact (for content): Mitch Monco
Drafter: Sophia Shin
Date: January 5, 2012
File Name with Path: Z:\Briefing Notes\DBN-IBN\2011\909885 - Minister's meeting with Ondine Biopharma Corp.docx

Notes on Barbara Mowat
Prepared by Spark Research & Reports 18/08/11

Brief Overview:

- **President/Owner Impact Communication Ltd.**
- **Member/Facilitator for the Vancouver Chapter of the Women President's Org.**
- **Member: Global Banking Alliance for Women**
- **Founder/Publisher of Home Business Report**
- **Founder/Owner of uniquelycanada.com (e-commerce gift store)**
- **Founder/Owner of GroYourBiz.com**
- **1993 Canadian Women Entrepreneur of the Year for Impact on the Local Economy**
- **Recipient of the 2010 Governor General's Award Commemorating the Persons Case**

Ms. Mowat is President of Impact Communications Ltd. and GroYourBiz.com, Corporate and Non-Profit Director, and Chapter Chair of three Vancouver chapters of the Women Presidents' Organization. Impact Communications Limited, a multi-faceted consulting company working in the areas of management training and consulting; creation of training and business resources; and, international product, business and market development for the global marketplace, including creating and producing trade shows, conferences, forums, and trade missions. Barbara has spent over 25 years helping to advance the status and strength of women business owners in Canada and in third world countries. She has done so by helping countless micro and SMEs to start-up, grow, leverage, trade, and position for sale. Barbara's business development and international trade expertise has been sought after by global financial institutions and governments of third world countries to help economically challenged women and children thrive by developing successful micro-businesses. Barbara has devoted her relentless energy and business strength to tackling some of society's most difficult challenges by empowering women to become successful business owners and respected business leaders. She is fully committed to the long-term success of the people who surround her, and especially the disadvantaged.

Barbara Mowat has over thirty years of professional experience as a business owner and management and training consultant. She was the founder and publisher of Home Business Report, the first Canadian national newsstand magazine for micro-enterprises. She is founder and owner of UniquelyCanada.com, an e-commerce gift store for SME enterprises and creator of the Uniquely Programs, which assists entrepreneurs in accessing the global marketplace, with a special emphasis on women. Ms. Mowat's work has assisted entrepreneurs throughout Canada, South-East Asia, the US, South America, Europe, Afghanistan, and Africa. She sits on a number of boards and committees concerned with issues related to small business development. These have included: UBC Entrepreneurship & Venture Capital Research Centre; Board of Director for the Canadian Council for Small Business; Chair of the Small Business Advisory Committee for the Royal Bank of Canada; Member of the Small Business Working Committee for the Ministry of Finance and Ministry of Industry; Member of the Treasury Board of Canada's Joint Forum on Small Business Issues; Vice-Chair of the Canada BC Business Services Society; and Vice-President of Memberships for International Women's Forum Canada. She is currently on the Advisory Board of KCTS Public Broadcasting TV station in Seattle, Washington, as well as facilitator for the Vancouver Chapter of the Women President's Organization (WPO). Her Daughter is Brittany Manulak (Jason) Concept Plumbing and Gas Abby/on Crystal Gala

Notes on Carolyn Cross, CEO Prepared by By Spark Research & Reports

- **Company Name:** Ondine Biopharma Corporation
- **Type of Industry:** Medical devices Photodisinfection, Photodynamic therapy
- **Major Service:** Periowave, Endowave, MRSAid, Vitalwave, Sinuwave
- **Education:** Masters of Business Administration, York University, Honours Business Administration, University of Western Ontario
- **Business contact details:** Address: #888-1100 Melville Street, Vancouver, BC V6E 4A6 Canada and 19017 - 120th Ave NE, Suite 102, Bothell, WA 98011, USA
- **Affiliations:** Businesswomen's Association: www.womenpresidentsorg.com
Toronto Society of Financial Analysts: www.torontocfa.ca;
- **See also:** www.ondinebiopharma.com; www.periowave.com; www.MRSAid.ca;
www.endowave.com; www.sinuwave.com; www.vitalwave.com;
- **Member:** Board of the International Photodynamic Association

Except from: Business in Vancouver May 30-June 5, 2006; issue 866 (By Krisendra Bisetty)

Ondine Biopharma Corp. CEO Carolyn Cross is navigating the Vancouver biotech through tricky waters in the volatile global biotechnology marketplace

Mission: To create and commercialize leading edge products using photodynamic disinfection technology

Assets: Stubborn perseverance and expertise gleaned from founding venture capital and fund management companies

Yield: Riding herd on a biotech company with offices in Vancouver and Washington state that has ambitions to move to the forefront of the world's antimicrobial marketplace

Carolyn Cross wants to be a bug's worst nightmare.

As antibiotic-resistant micro-organisms flourish around the world, the president and CEO of Ondine Biopharma Corp. (TSX-V:OBP) is quietly positioning the Vancouver company to be in the forefront of an intensive global search for a new level of antimicrobials. Ondine's patented Periowave PhotoDynamic Disinfection technique targets bacteria for rapid destruction, and Cross believes the technology is what the multibillion-dollar periodontal disease market has been for waiting with bated breath. According to the company's claims, the non-antibiotic technology, which uses laser activation of topically-applied proprietary compounds, represents a new era in broad-spectrum microbial control in applications from dentistry to trauma wounds and even toenail fungus infections. Ondine launched its product in the Canadian market in March, the same month it received the regulatory CE mark of approval to market the system throughout Europe.

"Periowave is a product that is positioned to be an adjunct to the current treatment of gum disease, the most prevalent human disease out there," said Cross, a former fund manager and vice-president with Toronto-based Royal Bank Investment Management Inc., an arm of the Royal Bank of Canada. Periodontitis is a common human oral disease that affects one-third of all adults and over half the world's population over the age of 50. The primary treatment for periodontitis is scaling and root planing, which involves the scraping away of plaque build-up and bacterial pockets underneath the gum line.

"It's a very painful and bloody procedure," said Cross. "The professionals do the best that they can, but they do leave quite a bit of bacterial residue behind and we are positioning our product to come in afterwards and disinfect the bugs that are left behind in that process." The technology was developed by Prof. Michael Wilson and colleagues at the University College London's Eastman Dental Institute and licensed to Ondine via its UCL Biomedica PLC subsidiary. Cross got involved with Ondine, then known as SBL Technologies, in 1999, four years after moving from Toronto to Vancouver, where she started Vencourt Capital, which provides capital and management expertise to early stage companies. Before Ondine, Cross also started Courthill Capital, a fund management company. Bringing a company like Ondine to the market takes "lots of guts and stubbornness," she said. "There's no glory here. It's just all about stamina because it is the hardest type of company to run. "It's one that's under-supported by the investment community because there are so many failed start-ups in the life sciences because of the extra challenges that regulatory risk does pose. "It takes a lot of perseverance and passion to pull something like this off."

Ondine spent \$18 million getting its first product to the commercialization stage. Cross said the project was under budget and a testament to the work by Ondine's 34 employees, split roughly between Vancouver and its research laboratory in Redmond, Washington, which is run by chief technology officer Nicolas Loebel. In April, U.S. industry veteran Jacqueline Walker, a former vice-president and general manager at dental products company Dentsply International was hired to run its American subsidiary Ondine Biopharma (U.S.A) Inc. and to lead global commercialization efforts. "When you start getting seasoned industry veterans leaving their jobs and joining your company because they understand the potential and the buy-in to the passion and the resolve to move something forward, it validates the technology, validates the effort and it validates the enormous sacrifices [of] the team currently in place," said Cross.

While the immediate focus will be to market the product among Canada's periodontal and dental community and launch it in Europe later this year, Ondine hasn't sought regulatory approval yet for its biggest potential market, the U.S., although it has its sights firmly set on it. "My style, because of my fund management background, is very much one oriented towards risk mitigation rather than just return orientation," said Cross. If she doesn't get it right, the repercussions will be huge, which is why Canada is being used as a test run for a year. "I want to make sure that I really learn how to position a revolutionary new technology in the marketplace before I roll that out across the U.S. market place." Margaret Shaw, a former Toronto fund portfolio manager and long-time friend of Cross, said the strategy is typical of her. "I've met a lot of interesting and well-educated people, both of which she is, but she's also more of a visionary. This is someone who can see out a few years. That's the way her scope tends to lead here." Ondine also sees other applications for its technology, including halitosis or what Cross calls the "bad breath" market. Off-the-shelf products are also in the pipeline, including a photo-activated laser disinfection toothbrush which Cross said has drawn interest from one of three major electric toothbrush companies. "We're obviously looking to partner with a well-established group," she said. "Having built the platform of non-antibiotic approaches to anti-infection, I'm now see many opportunities that are coming our way."

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

CLIFF #: 913071

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

TITLE: Meeting with Dr. Patrick McGeer, Canadian Dementia Action Network,
January 19, 2012.

PURPOSE: Information to brief the Minister for a meeting with Dr. McGeer from the Canadian Dementia Action Network which is seeking research funding for their proposal for defeating Alzheimer's disease.

BACKGROUND:

- Over 60,000 British Columbians are currently living with Alzheimer's disease or a related dementia and this number is expected to more than double in the next 25 years.
- In 2006, the Premier announced \$15 million in funding, through the Ministry of Advanced Education, for the Pacific Alzheimer Research Foundation (PARF) to support new research aimed at eliminating Alzheimer's disease and related dementias. PARF also sponsors the Canadian Dementia Action Network (CDAN).
- CDAN is a not-for-profit company registered under the *Canada Corporations Act*. It has charitable status. According to CDAN, it has been created as a Canadian initiative to meet the dementia crisis and to achieve the goal of eliminating Alzheimer disease and related dementias. Efforts are 100 percent focused on goal driven research to develop effective treatments and cures for dementia diseases.
- Dr. Patrick McGeer, as director of the PARF, actively solicited leading scientists to apply for grants through CDAN to conduct research in finding ways of preventing or arresting Alzheimer's disease and related dementias.
- Dr. McGeer is an Officer of the Order of Canada and a member of the Order of BC, a former BC Cabinet Minister, Professor Emeritus in University of BC's (UBC) Faculty of Medicine and an internationally-recognized researcher on Alzheimer's disease.
- At this upcoming meeting, Dr. McGeer is making a presentation to seek \$12.5 million funding support from BC for funding CDAN's research program.

DISCUSSION:

- In 2007, BC committed \$2.8 million in funding through the Alzheimer's Drug Therapy Initiative (the Initiative) for research into effectiveness of cholinesterase inhibitors. The research proposal was peer reviewed and is being undertaken by researchers at the University of Victoria and the UBC.

- The Initiative provides PharmaCare coverage of cholinesterase inhibitors with evidence development to assist PharmaCare in making an informed listing decision; the Initiative also funds a comprehensive dementia education program for health professionals.
- Current drug treatment may delay the onset of the disease but is not a cure. The Initiative addresses the clinical effectiveness of an existing Alzheimer's drug treatment and does not address the areas noted below.
- CDAN consists of nine teams of medical researchers headed by leading clinical experts to address each area identified as necessary to defeat Alzheimer's disease:
 1. basic research
 2. animal modelling
 3. brain banking
 4. clinical research
 5. clinical trials & industry relations
 6. prevention
 7. genetics
 8. neuroimaging
 9. knowledge translation & exchange
- CDAN is seeking grant funding from the federal government, provinces and territories in the amount of \$245 million over 5 years. They anticipate that the federal government will provide the largest contribution.
- CDAN is seeking \$2.5 million annually from BC, or \$12.5 million over 5 years, which represents 5 percent of the total research program budget.
- A research proposal of this magnitude and scope should be evaluated through a peer-review process by major health research funding agencies such as Canadian Institutes of Health Research, the Michael Smith Foundation for Health Research and Genome BC. It is unclear as to the effort this group has explored for these typical funding sources.

ADVICE:

S. 13

Program ADM/Division: Bob Nakagawa / Pharmaceutical Services
Telephone: 250 952-1705
Program Contact (for content): Eric Lun / Ron Mattson
Drafter: Caroline Caiger
Date: January 12, 2012
File Name with Path: S:\DrugIntelligence\Briefing Notes\2012\913071 IBN Minister Meeting with McGeer CDAN.docx

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Chiff # 913152

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

S. 12

Pages 50 through 54 redacted for the following reasons:

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927456

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

TITLE: Minister's Meeting with Loblaw Companies Limited

PURPOSE: To provide background information on pharmacy policy to be discussed on May 10, 2012 with senior officials from Loblaw Companies Limited.

BACKGROUND:

Loblaw Companies Limited (Loblaw) is Canada's largest food retailer and a leading provider of drugstore, general merchandise and financial products and services. They are one of the country's largest private-sector employers, operating more than 1,000 corporate and franchised stores— 53 Loblaw pharmacies operate in 41 communities across British Columbia, under the banners of Extra Foods, nofrills®, Real Canadian Superstore and Wholesale Club.

Loblaw is a member of the Canadian Association of Chain Drug Stores (CACDS) and also currently has a representative on the CACDS board of directors. The CACDS represents their members' viewpoints to governments, stakeholders and the public. CACDS claims to advocate the impact of issues and legislation on the business of community pharmacy and its ability to deliver effective, frontline health care.

The CACDS participated in the negotiation of the Pharmacy Services Agreement (the Agreement). The Agreement was signed between the Ministry of Health (the Ministry), the BC Pharmacy Association and the CACDS, and came into effect on July 28, 2010. The Agreement was to result in up to \$380 million a year in total savings for BC taxpayers and the health care system by reducing the price the province paid for generic drugs.

However, much of the savings did not materialize and the Agreement was terminated by the Ministry on April 1, 2012. The shortfall in actual net savings was due primarily to the volume of generic drugs for which manufacturers had requested exceptions to the pricing thresholds that were set out in the Agreement.

While the Agreement has been terminated, many policies that resulted from the Agreement continue to be in effect, including limits on prices for generic drugs (currently 35 percent of the brand name price in BC). See Appendix A for a list of enhancements to pharmacy compensation that resulted from the Agreement.

On April 24, 2012, Bill 35, the *Pharmaceutical Services Act* was introduced into the House. The *Pharmaceutical Services Act* shifts the PharmaCare program from one which relies on government policy, to a program protected by legislation and also creates the framework to allow the Ministry to regulate and further lower drug prices.

Through legislation, the Province plans to lower generic drug prices to be in line with other jurisdictions. Ontario was the first jurisdiction to pass similar legislation in 2006 through Bill 102, the *Transparent Drug System for Patients Act*. Loblaw has noted the cooperative role that they played with respect to the implementation of Ontario's legislation and they are interested in learning more about BC's plans for changes in pharmacy policy.

DISCUSSION:

S. 13

Program A/ADM/Division: Darlene Therrien, Pharmaceutical Services

Telephone: 250-952-1705

Program Contact (for content): Mitch Moneo, A/Executive Director

Drafter: James Kerr

Date: May 7, 2012

File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\927456 - Minister Meeting with Loblaw Companies Limited.doc

Appendix A

Enhancements to pharmacy compensation resulting from the Pharmacy Services Agreement

July 28, 2010	Maximum dispensing fee increased to \$9.10 from \$8.60
October 15, 2010	Maximum dispensing fee increased to \$9.60
	Maximum drug cost markup increased to eight percent from seven percent
	Maximum plan B capitation fee increased to \$43.75 from \$35.00
November 1, 2010	Expansion of the Rural Incentive Program and application process changes
April 1, 2011	Pharmacies receive between \$15.00 and \$70.00 for providing medication review services
July 4, 2011	Maximum dispensing fee increased to \$10.00

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #914137 xref 908542

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

TITLE: Eating Disorders and Access to Treatment Options, Programs and Community Supports within Health Authorities.

PURPOSE: To provide an overview of health authority policies on access to Mental Health and Substance Use (MHSU) treatment programs, including eating disorders, as well as readmission requirements for Discovery and VISTA programs at St. Paul's Hospital (St. Paul's).

BACKGROUND:

On January 12, 2012, the Honourable Michael de Jong, QC, Minister of Health (the Minister) met with an advocacy group for Adults with Eating Disorders in British Columbia to discuss the system of care for eating disorders in BC. As a result of the issues raised by the advocacy group, the Minister requested additional information on access to treatment programs and readmission requirements for Discovery and VISTA programs at St. Paul's Hospital.

DISCUSSION:

S. 13

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: 250-952-1049
Program Contact (for content): Ann Marr, Executive Director, Mental Health & Substance Use
Drafter: Will Thomas, Manager, Mental Health & Substance Use
Gerrit van der Leer, Director, Mental Health & Substance Use
Date: February 2, 2012
File Name with Path: Y:\HAD General\Briefing Notes\2012\MHSU\914137 Eating Disorders and Access to
Treatment Options Programs and Community Supports within HAs approved by Heather Davidson Feb 2 12.docx

Provincial Specialized Tertiary Eating Disorders Program for Adults

Discovery Day/Vista Residential Program

ADMISSION CRITERIA

1. Eating Disorder diagnosis (i.e., requires intensive support around meal-taking)
2. Must be deemed medically stable as per Medical assessor (i.e. ability to safely participate in the residential day program)
3. BMI of 16 or greater
4. Requires a higher level of care for their eating disorder than what is available in their community (non-acute)
5. Motivated to make behavioral and psychological changes, including changes in eating behavior and, if necessary, to increase weight
6. Participate in the preparatory program, Readiness Program, and any other pre-care and/or psychoeducational sessions as recommended by the team
7. Be able to maintain self free of drug/alcohol use during D/V Program
8. Be able to refrain from self-endangering behavior (e.g. cutting) during D/V Program
9. Be respectful to the residential day program group (i.e. agreeable to participating in group, not engaging in abusive or hostile behavior)

EXCLUSION CRITERIA

1. Medically unstable – requires acute medical intervention or hospitalization
2. Is not willing or ready to make eating behavior changes or to increase weight without intervention (i.e., requires admission to hospital, requires nasogastric tube feeding, or requires IV therapy for rehydration)
3. Non-voluntary status under the Mental Health Act
4. Is considered a high safety risk (i.e. actively planning or displaying self-endangering or suicidal behaviors) (will need 3 months stability)
5. Unable to participate in the residential day program (i.e. cognitive impairment, severe depression, psychosis, etc.)
6. Actively abusing drugs or alcohol (will need to have 3 months abstinent)

DISCHARGE CRITERIA

1. Non-attendance or repeated lateness or absences
2. Individual has indicated that he/she is not willing or wanting to make any changes in their eating disorder (i.e., no movement/shift from entry into the program)
3. Individual does not agree with or want to follow the guidelines
4. Behaviors which interfere with group interaction and participation (substance abuse, self-harm, significant changes in mood that require significant psychiatric intervention or admission to hospital, any verbal or physical abuse towards staff or other residents)
5. Individual requests to leave program

RE-REFERRAL/RE-ADMISSION CRITERIA

1. Meets regular admission criteria for D/V
2. At least 6 months has passed since discharge from D/V before re-referral is made
3. BMI is greater than or equal to the D/V discharge BMI (or 20.0, whichever is lower)
4. Assessor has clear rationale as to why a second admission would be beneficial for the patient
5. Patient has clear goals for re-admission (e.g., how this admission will differ from the previous one, how he/she will address any problems that arose in the previous admission)

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 903719

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

TITLE: Patient Care Quality Review Board Recommendation to the Minister of Health
Re: 11-0034

PURPOSE: To obtain a decision on the Minister of Health's (the Minister) response to the Vancouver Island Patient Care Quality Review Board's recommendation to standardize fee information provided to patients who are non-residents of Canada.

BACKGROUND:

On November 8, 2011, the Vancouver Island Patient Care Quality Review Board (the Board) issued its decision regarding the complaint case of S. 22 complained about the invoice S. 22 received following treatment at Nanaimo Regional General Hospital. S. 22 would be charged the day care surgery rate but was instead charged the acute care ward rate.

Following its review, the Board recommended that the Minister have staff review the Non-Resident of Canada (NRC) Agreements, Visitor Rates, Visitor Rate Sheets, and any written information used to describe these items to ensure that they are standardized across the health authorities, and that NRC Agreements and Visitor Rate Sheets are available in a number of different languages.

The Boards have been encouraged to ensure their recommendations are supported by a body of evidence. This marks the first time the Vancouver Island Board has made a recommendation on this topic. While there have been no previous recommendations regarding the specific issue of NRC rate sheets, this recommendation supports a key theme identified in the Board's 2010/11 Annual Report regarding clear communication with patients and families.

DISCUSSION:

The Ministry of Health's (the Ministry) Patient Care Quality team analysed health authority materials presented or used to explain charges to NRC patients and their families. Health authority rate and service information varies in the degree of detail and format.

Standardized hospital rates for NRC patients are set by the Chief Financial Officers Committee, and are updated annually. However, the Ministry also permits health authorities to bill NRC patients for supplies and services where itemized billing is possible and where individual circumstances warrant, i.e. such as the complexity of the procedure, third party insurance applicability, etc. (see Appendix A for the Ministry's policy).

The policy states health authorities must advise NRC patients of charges and payment terms upon admission; however, approaches taken to inform NRC clients about these rates and their responsibilities around payment vary. The Ministry reviews the policy on a periodic basis.

The policy was amended to permit health authorities to sustain consistency in NRC rates developed while at the same time, permit flexibility in charging NRC patients appropriately for services rendered, i.e., recognizing that NRC patients are a distinct client group from BC or other Canadian citizens.

Although the Board's recommendations are well intentioned, in this instance the area of concern falls more within the purview of Ministry policy and oversight.

S. 13

Approved/Not Approved
Honourable Michael de Jong, Minister

Date Signed

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: 250 952 1530
Program Contact (for content): Teri Collins, Executive Director, HARCS, HAD, Gordon Cross, Executive Director, Regional Grants and Decision Support, FCS
Drafter: Gordon Cross
Date: January 19, 2012
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Appendix A

(Note: Add Molt Policy as appendix).



MINISTRY OF HEALTH SERVICES

POLICY COMMUNIQUÉ

COMMUNIQUÉ

TO: Health Authority Chief Executive Offices

TRANSMITTAL DATE: OCT 19 2010

COMMUNIQUÉ 2010-09
NUMBER:

CLIFF NUMBER: 856186

SUBJECT: Ministry of Health Services Policy – Charges to
Non-Residents of Canada for Health Care Services

DETAILS: Ministry of Health Services Policy

EFFECTIVE DATE: April 21, 2010

MINISTRY CONTACT: Gordon Cross
Executive Director
Regional Grants and Decision Support

John Dyble
Deputy Minister
Ministry of Health Services

MINISTRY OF HEALTH SERVICES POLICY

RATIONALE

The Ministry has consented to health authorities modifying their current billing practices for health care services to non-residents of Canada (NRC) by adopting an itemized billing approach. The itemized billing approach varies from the current approach allowing health authorities to bill NRC patients for specific medical supplies and services, in addition to NRC standard ward and operating room rates agreed to by the Chief Financial Officers and the Ministry.

POLICY OBJECTIVE

A common policy framework is necessary to ensure that consistency across health authorities regarding charges to NRC inpatients is sustained. Consistency was previously achieved through charging the same amount in every hospital in the province for standardized services measured in the following units: days in standard wards or intensive care units, hours in the operating rooms, number and type of high cost diagnostic tests and physician visits, if the physician is employed by the health authority.

SCOPE

This policy applies to patient NRC charges for which health authorities are accountable.

POLICY

- Health authorities may use the itemized billing approach to NRC patients where appropriate taking into account such matters as complexity of the procedure, third party insurance applicability, emergent care factors, etc.
- In instances where health authorities do not have the capacity to provide itemized bills to NRC patients or deem it not appropriate, health authorities will continue charging NRC patients based on standardized services measured in the following units: days in standard wards or intensive care units, hours in the operating rooms, number and type of high cost diagnostic tests and physician visits, if the physician is employed by the health authority.
- Health authorities are responsible for preparing itemized bills using a standard methodology.
- Health authorities will take all available actions to collect outstanding accounts promptly and cost-effectively.
- Health authorities must comply with all provisions of the *Canada Health Act* and other relevant provincial legislation and regulations.

IMPLEMENTATION

1. Health authorities will advise NRC patients of billing and payment terms upon admission to acute care facilities.
2. Health authorities will review the process annually through the Financial Reporting Working Group and Chief Financial Officers Committee and the Ministry.

ACCOUNTABILITY

Health authorities must ensure billings to all NRC patients comply with the policy and standards outlined in this communiqué. As well, health authorities must ensure that adequate safeguards are in place to prevent unauthorized access, disclosure and use of any personal patient information they obtain. The Ministry of Health Services will monitor compliance with this policy within the overall performance monitoring plan and service plans.

REVIEW

This policy is subject to review by March 31, 2011.

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Chiff # 907330

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

TITLE: Minister's Tour of the Valley Medical Imaging Clinic in Abbotsford

PURPOSE: To provide information for the Minister's tour of Valley Medical Imaging with Dr. Emil Lee on February 24, 2012.

BACKGROUND:

Medical Imaging

- Medical imaging procedures such as x-ray, ultrasound, computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) allow clinicians to view inside patients' bodies, without using invasive procedures, for diagnosis, prognosis, cancer staging, and treatment monitoring.
- Utilization is growing at a rapid rate. For example, between 2001/02 and 2010/11, the volume of MRI procedures in British Columbia increased 191 percent; 108 percent for CT.
- Medical imaging procedures are provided in Emergency, Inpatient and Outpatient settings. Publicly-funded outpatient procedures are provided by health authority owned and operated facilities and by privately owned and operated Community Imaging Clinics (or CICs).

Valley Medical Imaging (Valley X-ray Services Ltd)

- Valley X-ray Services Ltd. is a CIC that operates three private clinics under the name of Valley Medical Imaging (VMI) in Abbotsford, Langley, and Chilliwack, providing diagnostic x-ray, mammography, ultrasound, and MRI services.

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BC Radiological Society

- Dr. Emil Lee is the current President of the BC Radiological Society (BCRS), a non-profit organization that represents radiologists practicing in the province. BCRS Executive Council represents radiologists at negotiation and arbitration tables.

Langley Memorial Hospital (LMH)

- LMH is a community hospital providing 24/7 emergency care, ambulatory care, general surgery, critical care, x-ray, CT, ultrasound and a range of specialized services.
- In February 2010, the province funded a \$2.9 million expansion and renovation of the medical imaging department that made space for a new 64-slice CT scanner. The scanner provided 9,990 CT scans in 2010/11.

Abbotsford Regional Hospital and Cancer Centre (ARHCC)

- ARHCC opened its facility in 2008, replacing the previous Matsqui Sumas Abbotsford (MSA) Hospital. The 300-bed facility provides general surgery, renal dialysis, specialized obstetrics and nursery care, pediatrics, cancer care and other specialized services, and a full range of medical imaging services including x-ray, CT, ultrasound, MRI, mammography and nuclear medicine.
- The facility has two CT machines and one MRI machine. 19,905 CT procedures and 4,322 MRI procedures were provided in 2010/11.

S. 13

Program ADM/Division: Heather Davidson, Health Authorities Division

Telephone: 250 952-1514

Program Contact (for content): Bffie Henry, Executive Director

Drafter: Katharine Krystalowich

Date: Feb 21, 2012

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Page 69 redacted for the following reason:

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 909451

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

TITLE: Alzheimer Society of British Columbia Questions about Provincial Dementia Action Plan, Provision of Alzheimer's Medications, and Request for Increased Funding for FirstLink® Service

PURPOSE: To provide updates/advice for Minister's meeting with Alzheimer Society of BC on Wednesday, January 18, 2012, 2:45-3:30 pm. Location: PVO Boardroom 1, 999 Canada Place, Suite 740, Vancouver

BACKGROUND:

The Alzheimer Society of BC (ASBC) provides British Columbians with Alzheimer's disease and other dementias, and their caregivers, with access to a range of information and services to help them manage a progressive, debilitating condition.

In 2007, the Ministry of Health (the MoH) developed the Dementia Service Framework (the Framework) in collaboration with ASBC, clinical specialists and health authority representatives. The Framework has more than 130 recommendations to improve services for people with dementia and their caregivers, and is posted on ASBC's website.

In 2008, MoH gave ASBC \$1M grant funding to pilot initiatives from the Framework. ASBC used the funds for seven projects, including introducing FirstLink® which is an early intervention strategy to give people with Alzheimer's disease and their caregivers information and support.

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S. 17, S. 13

In October 2007 the Province launched the Alzheimer's Drug Therapy Initiative (ADTI) to provide coverage with evidence development for medication for individuals with mild to moderate Alzheimer's disease. The cost of the ADTI was originally budgeted at \$77M over 3 years; \$2.4M was dedicated to research and \$400,000 for physician education. Due to the lower than expected uptake, the Initiative has been extended until February 2014 when the Pharmaceutical Services Division (PSD) is expected to make a listing decision on these medications. The ASBC has been a member of the ADTI's Project Advisory Committee since its inception in 2007.

Currently, the MoH is finalizing the draft Provincial Dementia Action Plan (PDAP), which ASBC and other stakeholders helped to inform. The PDAP may be released in March, 2012. It aims to focus health activities and support dementia care as a key priority for integrated primary and community care.

S. 13, S. 17

S. 13, S. 17

Program ADM/Division:	Heather Davidson, ADM, Health Authorities Division
Telephone:	250-952-1297
Program Contact (for content):	Katie Hill, Director Home Community and Integrated Care
Drafter:	Pauline James, Manager Priority Populations and Service Redesign
Date:	January 12, 2012
File Name with Path:	Y:\HAD General\Briefing Notes\2012\HCIC\909451 MO Mtg Alzheimer Society Jan 18 2012_V2 approved by Heather Davidson and Manjit Sidhu Jan 13 12.doc

Page 72 redacted for the following reason:

S. 13

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

CHIT # 912544

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

TITLE: Update – Provincial Dementia Action Plan

PURPOSE: To outline the status, timelines and key priorities outlined in the Dementia Action Plan

BACKGROUND:

In 2007, the Ministry of Health (the Ministry) released the Dementia Service Framework (the Framework). Developed in collaboration with the Alzheimer's Society, clinical specialists and health authority representatives, the Framework outlined more than 130 recommendations to improve services for people with dementia and their caregivers.

A Ministry grant of \$1 million was provided to the Alzheimer's Society in 2008, to pilot initiatives from the Framework. The Alzheimer's Society was also provided \$1M grant funding for each of three years 2009/10 – 2011/12 to pilot an early intervention strategy, called First Link.

S. 13

DISCUSSION:

S. 13

S. 13

Program ADM/Division: Heather Davidson, ADM Health Authorities Division
Telephone: (250) 952-1297
Program Contact (for content): Leigh Ann Seller, ED, Home Community and Integrated Care
Drafter: Katie Hill, Director Service Redesign and Integration
Date: January 3, 2012
File Name with Path: YAHAD General\Briefing Notes\2012\HCIC\912544 Update Provincial
Dementia Action Plan approved by Heather Davidson Jan 4 11.doc

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #: 913636

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

TITLE: BC Care Providers Association Request for Meeting with Minister

PURPOSE: To provide background information on the BC Care Providers Association request for a follow-up meeting to discuss their document "*Proposals to Improve Quality and Efficiency of BC Seniors Care*"

BACKGROUND:

The BC Care Providers Association (BCCPA) is an advocacy organization representing the interests of private providers of residential care, assisted living and home support services. The organization represents approximately one-third of facility providers in the province, primarily the for-profit sector.

Ministry of Health (the Ministry) staff meet regularly with the BCCPA, and include them in discussions with health authority leaders in home and community care services on a regular basis.

Members of the BCCPA participated in two Ministry organized Forums in 2011/12, along with health authorities, physicians, non-profit service providers and other stakeholders to discuss the strategic direction for home and community care services, and the Ministry's goals for the health system.

Key issues for the BCCPA include opportunities for additional contracts for services, requirements for compliance with provincial policies on client charges and service provisions, implementation of a standard provincial contract for residential care services, and establishment of a single provincial funding model for services.

The BCCPA regularly request meetings with the Minister to speak directly to issues of interest to their members.

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: 250 952-1297
Program Contact (for content): Leigh Ann Seller, ED, Home, Community and Integrated Care
Drafter: Katie Hill, Director
Date: February 3, 2012
File Name with Path: Y:\HAD General\Briefing Notes\2012\HCIC\913636 BC Care Providers Association Request for Meeting with Minister approved by Heather Davidson Feb 4 12.doc

Pages 77 through 78 redacted for the following reasons:

S. 13

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 915955

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

TITLE: Funding of Residential Substance Use Services

PURPOSE: Upcoming meeting between the Minister of Health and VisionQuest
Recovery Society

BACKGROUND:

The majority of people needing help to change their substance use will find the assistance they need in non-residential community-based services. Some, however, will require the more structured and intense supports offered by residential services. These services offer time-limited accommodation, in which clients are expected to refrain from alcohol and illegal substances. Some clients will need to participate in withdrawal management (detox) programs prior to admission.

One of the actions in Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia is to provide evidence based treatment options in youth and adult residential substance use programs, including abstinence based programs as well as those based on harm reduction.

DISCUSSION:

S. 13

Program ADM/Division: Heather Davidson/Health Authorities Division

Telephone: 250-952-1049

Program Contact (for content): Ann Marr

Drafter: Amanda Seymour, Anita Snell, Emily Quinn

Date: January 26, 2012

File Name with Path: Y:\HAD General\Briefing Notes\2012\MHSU\915955 - Briefing Note for Minister Meeting with VisionQuest - February 9 2012 approved by Heather Davidson Feb 6 12.docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 916367: Xref 914074

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

TITLE: Meeting with Representative of Children and Youth re: Investigative
Report being released concerning the deaths of the S. 22

PURPOSE: Background information for meeting week of February 13-16, 2012

BACKGROUND:

In January 2012, the Mental Health and Substance Use (MHSU) branch in the Health Authorities Division reviewed a draft copy of the Representative for Children and Youth's report resulting from her investigation into the deaths of S. 22
S. 22 The following "Discussion" section is based on MHSU's review of the draft report.

DISCUSSION:

S. 13

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: 250-952-1049
Program Contact (for content): Ann Marr, Executive Director, Mental Health & Substance Use
Drafter: Anita Snell, Director, Mental Health and Substance Use
Date: January 30, 2012
File Name with Path: Y:\HAD General\Briefing Notes\2012\MHSU\916367 Minister meeting
with rep Children and Youth xref 914074 approved by Heather Davidson Feb 4 12.docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

Chiff # 916527

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

TITLE: Minister's meeting with British Columbia Cancer Foundation (the Foundation)

PURPOSE: To provide background on the Foundation for the Minister's meeting with Jess Ketchum, Greg D'Avignon and Doug Nelson

BACKGROUND:

- The Foundation is the fundraising partner of the BC Cancer Agency (BCCA).
- It is the largest charitable funder of cancer research in BC.
- Jess Ketchum – Director and Board Chair (Volunteer)
- Greg D'Avignon – Director and Chair, Development Committee (Volunteer)
- Doug Nelson – President and CEO
- Initiatives in the 2010/11 year included:
 - establishment of a new research chair in cancer survivorship at Simon Fraser University;
 - purchase of a second PET/CT scanner for the province;
 - development of an ovarian cancer research program; and,
 - implementation of the BC Generations Project – a multi-year, multi-generational survey and data collection project designed to learn about cancer incidence and other chronic diseases in BC.
- Due to a \$10 million fundraising initiative by Alex Campbell, the BC Cancer Agency's Vancouver Island Centre has started work on an expansion and renovation to improve patient care. Construction is expected to be completed at the end of 2012.
- The Foundation also launched a "Partners in Discovery" brand and new website to further promote collaboration between philanthropists and researchers.

DISCUSSION:

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: 250-952-3519
Program Contact (for content): Rebecca John
Drafter: Donna Bush
Date: February 8, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\916527
- MdJ Mtg Feb 13 with BC Cancer Foundation.doc/DM approved Feb 10, 2012

¹ BC Cancer Foundation 2010/11 Audited Financial Statements (June 2011.)
www.bccancerfoundation.com.

Pages 85 through 103 redacted for the following reasons:

S. 13, S 17

S. 17 and S. 21

**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

Cliff # 918361

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

TITLE: Mental Health Commission of Canada (MHCC)

PURPOSE: To provide information in support of a meeting between the Minister and the MHCC at the Manitoba Summit, "Mental Health Promotion and Mental Health for all" on February 15-16, 2012

BACKGROUND:

The Mental Health Commission of Canada (MHCC) was established to promote mental health in Canada, and to work with stakeholders to change the attitudes of Canadians toward mental health problems, and to improve services and support.

- In November 2009, the MHCC released their strategy document *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*.
- The MHCC has since identified eight strategic directions, with the first five setting an agenda for transformation, while the remaining three focus on building capacity to enable transformation. A final draft of the strategy was circulated for feedback in December 2012. British Columbia has provided considerable input.
- In addition to developing a strategic direction for Canada, the MHCC initiated and funded a series of demonstration projects across Canada with little involvement of the provinces. One such project, the "At Home/Chez Soi" homelessness demonstration project has been piloted across Canada including in BC.

DISCUSSION:

S. 13

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: 250-952-1049
Program Contact (for content): Ann Marr, Executive Director, Mental Health & Substance Use
Drafters: Ron Duffell
Date: February 9, 2012
File Name with Path: YAMCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\918361 - MHCC meeting in Winnipeg.doc/approved by DM Feb 10, 2012

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 919399

PREPARED FOR: Honourable Michael De Jong, QC, Minister of Health and
Honourable Steve Thomson, Minister of Forests, Lands and
Natural Resource Operations – **FOR INFORMATION**

TITLE: MLA Steve Thompson re: Portage Keremeos

PURPOSE: To provide information re: Funding and Intake Process Issues

BACKGROUND:

The Crossing at Keremeos (the Crossing), operated by the Portage Program for Drug Dependencies (Portage), is a 42-bed, long term residential treatment centre for youth aged 14-18 years experiencing substance use problems. The Crossing opened in January 2009; it is a partnership among Vancouver Coastal Health Authority (VCHA), Fraser Health Authority (FHA), Interior Health Authority, Central City Foundation, From Grief to Action, and Portage. VCHA contracts for 27 beds at the Crossing and FHA contracts for the other 15 beds. Referrals are accepted from across the province when there are available beds.

Best practice in working with youth and families, including those with problematic substance use, indicates that the least intrusive treatment option should be considered first. The preferred substance use treatment model is to keep youth in their home and/or community. However, there are circumstances in which youth are best treated outside of their home and/or community such as when there are significant risk factors present in the youth's environment. Some of these risk factors include presence of substance use in the home by others, and/or being sexually exploited in the community. Sometimes youth self-identify as preferring to leave their home and community to receive treatment.

Youth who require residential treatment will have more complex conditions and, consequently, higher care needs. Youth with complex issues (e.g., suicidal ideation or self-harming behaviours) require highly trained staff in order to ensure safety and to address their complex needs. The program at the Crossing is based on a therapeutic community (TC) model which primarily utilizes a peer-driven approach to treatment.

DISCUSSION:

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Screening and assessment are conducted in the community by a practitioner trained in substance use assessment practice. Screening gathers limited information in order to identify the next appropriate steps for the individual seeking service. This may be that no service is required or that further assessment is needed to determine the right substance use service from the available continuum. Further assessment covers more detailed information about the individual's substance use, the issues that underlie it, and matters such as housing, employment, health, and social and familial relationships. It is necessary to make a full bio-psycho-social-spiritual assessment of each youth seeking substance use services in order to match her or him to the most appropriate program(s) and supports.

ADVICE:

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: 250-952-1049
Program Contact (for content): Ann Marr, Executive Director, Mental Health and Substance Use
Drafter: Anita Snell, Director, Mental Health and Substance Use
Date: March 5, 2012
File Name with Path: YAMCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\919399
 - Information BN Portage Funding and Intake Process Issues.docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 919910

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

TITLE: BC Care Providers Association

PURPOSE: To provide background information for a meeting with representatives of the BC Care Providers Association on February 23, 2012

BACKGROUND:

The BC Care Providers Association (the Association) is an advocacy organization that represents operators of some of the residential care, assisted living facilities and home support agencies in the Province. The members are predominantly owners of for-profit facilities.

Association members own and operate approximately one-third of the publicly funded facilities in the province.

Staff and Board members of the Association meet with Ministry of Health (the Ministry) staff regularly. They provided a detailed submission to the Ombudsperson's investigation on seniors' care, and carry out regular advocacy work on behalf of their members.

The Association has several priority areas of interest, which have been laid out in meetings with health authorities and the Ministry, in their own BC Care Providers Action Plan, and most recently in editorial content issued to the media.

S. 13

Program ADM/Division: Heather Davidson, ADM Health Authorities Division
Telephone: 250 952-1297
Program Contact (for content): Leigh Ann Seller, ED, Home, Community and Integrated Care
Drafter: Katie Hill, Director, Home, Community and Integrated Care
Date: February 22, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\919910
- BC Care Providers Assn Minister Meeting Feb 23.doc

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 920626

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

TITLE: Representative for Children and Youth Schoenborn Report

PURPOSE: To provide information on the Ministry of Health (MoH) response to the recommendations made by the Representative For Children and Youth regarding the Schoenborn Report.

BACKGROUND:

- On March 1, 2012, the Representative for Children and Youth (RCY) will release her report, *Honouring Kaitlynn, May and Cordon: Make Their Voices Heard* (the report), regarding the murder of three children in April 2008, by their father, Allan Schoenborn.
- The report emphasizes that these children were victims of "the upheaval and anxiety caused by domestic violence, untreated parental mental illness and addictions," and concludes that the deaths were preventable if the system of child protection and support had been appropriately applied.
- The report identifies a lack of coordination between the child welfare system, mental health system and the criminal and civil justice systems compounded by practice failures in the child welfare system.
- While the report recommends improvements to the coordination of the child welfare and mental health system it should be noted that the health system had first and last contact with Allan Schoenberg in June 1999, when he was certified under the *Mental Health Act* (the Act) showing signs of paranoia. As part of the assessment, hospital staff did alert the Ministry of Children and Family Development (MCFD) of child protection concerns and an investigation was undertaken. Schoenborn was hospitalized for seven days, treated with anti-psychotic medication, and left the hospital against medical advice when a second physician concluded that Schoenborn was not certifiable under the Act. He was discharged with a prescription for medication and attended one scheduled appointment with a psychiatrist. He did not continue with the prescribed medication or follow up appointments and from the records there is no evidence of any further contact with the mental health system until the deaths.
- The report indicates that from 1999 to April 2008, MCFD staff and local police departments had frequent contact with the Schoenberg family regarding domestic family violence and child safety concerns and parental mental illness was identified as a concern.

DISCUSSION:

- The report's first key recommendation is directed at MoH in partnership with MCFD and states that "Immediate steps need to be taken to ensure that all staff and professionals connected to their systems understand the risk factors relating to children of parents with a serious untreated mental illness and promote the well-being of children." In addition, the report outlines four specific actions to support this work including establishing policies and procedures for risk assessment, treatment and referrals when a parent has a mental illness to support children and families.
- The MoH response is to take immediate action on the recommendation. As there are already policies and procedures in place, we are in a position to build on what already exists as opposed to creating something new. Health authority care providers are required to assess the impact of an adult client's mental illness on their minor children and have a duty to report to MCFD if there is an immediate risk for the child. MoH will work with MCFD to review these procedures, determine how they can be strengthened based on the best evidence, and implement changes to meet the intent of the recommendation.
- With regard to physicians in particular, MoH in partnership with MCFD and the General Practice Support Committee of the British Columbia Medical Association, is in the process of developing and implementing guidelines for physicians for assessment and treatment of mental disorders. It can be made a priority to include in this work the identification of risk factors of children affected with parental mental illness and domestic violence, and in addition, create a specific section on this serious issue within the MoH's Family Physician Guide.
- It should be noted that most families impacted with mental illness are very capable of looking after their children. It is very stigmatizing to state and emphasize that children are at risk if their parent is mentally ill. In certain cases mental illness of family members needs to be assessed, however, mental illness does not preclude parenthood.

ADVICE:

- MoH agrees with the RCY's recommendations and feels that all levels of government have to work together to ensure vulnerable children and families are better protected. The MoH will ensure that all levels of the MoH, including health authorities, will work in partnership for better coordinated responses with MCFD and other government agencies in cases of mental health and family violence.
- In response to the specific MoH recommendation we will take action with an immediate review, in partnership with MCFD, of the existing policies, guidelines and protocols to determine how they can be strengthened to better support children when a parent has a mental illness.

Program ADM/Division: Heather Davidson, ADM, Health Authorities Division

Telephone: 250-952-1049

Program Contact (for content): Ann Marr, Executive Director, Mental Health and Substance Use

Drafter: Gerrit van der Leer, Director Mental Health and Substance Use

Date: February 24, 2012

File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\920626 - MO Mtg with Rep for Children and Youth re Schoenborn Report.doc

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 921412 (xref: 909885)

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

TITLE: Meeting with Ondine Biomedical Regarding MRSAid Business Case

PURPOSE: To prepare for meeting with Ondine Biomedical Inc. to discuss business case for implementing the MRSAid nasal decolonization system in health authorities.

BACKGROUND

- Ondine Biomedical Inc. (Ondine) is a privately-owned, British Columbia-based company marketing non-antibiotic therapies for treating a broad spectrum of infections, including Methicillin-resistant *Staphylococcus aureus* (MRSA).
- On January 16, 2012, Minister de Jong attended a presentation about the "MRSAid" nasal decolonization system given by Carolyn Cross, Chief Executive Officer, Ondine, and Dr. Elizabeth Bryce, Regional Medical Director of Infection Control, Vancouver Coastal Health Authority.
- The MRSAid system uses a low intensity light source to activate non-toxic chemicals in a patient's nasal passages in order to kill harmful MRSA bacteria and reduce the risk of surgical site infection.
- MRSAid treatments are typically administered by trained Licensed Practical Nurses.
- Ondine is proposing that the MRSAid system be rolled-out by the end of 2013/14 fiscal to all 24 BC hospitals involved in the National Surgical Quality Improvement Program (*see Appendices 1 and 2*).
- At the Minister's request, Ondine has developed a new business proposal that includes updated cost/benefit information (*see Appendices 3 and 4*) based on actual provincial surgical volumes.
- MRSAid technology is approved by Health Canada as a Class II medical device.
- **Please note** that the MRSAid system does not reduce *Clostridium difficile* infections; MRSA and *C. difficile* infections have different causal mechanisms.

DISCUSSION

S. 13

S. 13, S. 17

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Program ADM/Division: Heather Davidson, ADM, Health Authorities Division
Telephone: (250) 952-1049
Program Contact (for content): Brian Sagar, A/Executive Director, Clinical Care & Patient Safety
Drafter: Brian Sagar, A/Executive Director, Clinical Care & Patient Safety
Date: March 5, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing
Documents\2012\Approved\HAD\921412 - Minister Meeting with Ondine Biomedical re MRSAid
Business Case.doc

Pages 114 through 121 redacted for the following reasons:

S. 17 and s. 21

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 921652

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

TITLE: Alzheimer Society of British Columbia Meeting March 9, 2012

PURPOSE: To provide updates/advice for Minister's meeting with Alzheimer Society of British Columbia on Friday, March 9, 2012, 10:00 - 10:45 a.m.

BACKGROUND:

The Alzheimer Society of BC (ASBC) provides British Columbians with Alzheimer's disease and other dementias, and their caregivers, with access to a range of information and services to help them manage a progressive, debilitating condition.

In 2007, the Ministry of Health (the Ministry) funded the development of a Dementia Service Framework (the Framework) in collaboration with ASBC, clinical specialists and health authority representatives. The Framework has more than 130 recommendations to improve services for people with dementia and their caregivers, and is posted on ASBC's website.

In 2008, the Ministry gave ASBC \$1M grant funding to pilot initiatives from the Framework. ASBC funded for seven projects, including a prototype of their own FirstLink© which is an early intervention strategy to link people with Alzheimer's disease and their caregivers to community programs, information and support. S. 17

S. 17

The Ministry's recently released document, *Improving Care for B.C. Seniors: An Action Plan* commits to improved information to assist with understanding and living with dementia, including support by the ASBC's FirstLink program. The Action Plan also commits to develop guidelines for dementia care to promote evidence based practice in all care settings.

Currently, the Ministry is finalizing the draft *Provincial Dementia Action Plan*, which ASBC helped to inform. The *Dementia Action Plan* will be released in spring, 2012, and establishes quality dementia care as a key priority for integrated primary and community care.

In October, 2007 the Province launched the Alzheimer's Drug Therapy Initiative (ADTI) to provide coverage with evidence development for medication for individuals with mild to moderate Alzheimer's disease. The cost of the ADTI was originally budgeted at \$77M over 3 years; with \$2.4M dedicated to research and \$400,000 for physician education.

Due to the lower than expected uptake, the initiative has been extended until February, 2014 when the study results become available and when the Pharmaceutical Services Division (PSD) will make a listing decision on these medications. ASBC has been a member of the ADTI's Project Advisory Committee since its inception in 2007.

Meeting Purpose: ASBC has indicated that topics they wish to cover on March 9 include: (1) thanking the Minister for continued funding for FirstLink; (2) inquire when the *Provincial Dementia Action Plan* will be released; and (3) request that medications to treat Alzheimer's disease now available through the ADTI will continue to be available to patients through Special Authority coverage.

Program ADM/Division:	Heather Davidson, ADM, Health Authorities Division
Telephone:	250-952-1297
Program Contact (for content):	Katie Hill, Director Home Community and Integrated Care
Drafter:	Pauline James, Manager Priority Populations and Service Redesign
Date:	March 9, 2012
File Name with Path:	Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\921652 - MO Mtg Alzheimer Society March 9 2012.doc

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 924298

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

TITLE: Implementation Update - Office of the Auditor General's Infection Control Recommendations for the Ministry of Health and Health Authorities

PURPOSE: To update on progress by the Ministry of Health (the Ministry) and health authorities towards implementing infection prevention and control recommendations made by the Office of the Auditor General of British Columbia (OAG) in 2007.

BACKGROUND:

- Between July 2005 and February 2006, the OAG conducted a performance audit to assess infection prevention and control activities by the Ministry and health authorities.
- In March 2007, the OAG issued a report titled *Infection Control: Essential for a Healthy British Columbia* (the Report). The Report contained eighteen (18) recommendations for health authorities and two (2) recommendations for the Ministry.
- The OAG recommended that the Ministry:
 1. Implement a provincial framework for infection prevention, surveillance and control which at a minimum contains: comprehensive legislation, defined roles and responsibilities, surveillance, standards and reporting; and
 2. Establish provincial surveillance for hospital-acquired infections and work with key stakeholders to determine what should be reported.
- The OAG has issued updates in March 2008 and October 2009 that document work by health authorities in meeting recommendations from the Report.
- To date, the OAG has never followed up on the status of the two recommendations for the Ministry from the Report.

DISCUSSION:

Health Authority Progress to Date

- Health authorities have made significant progress in implementing the 18 recommendations (see Appendix A).
 - As of April 2010, 98% of the OAG's recommendations are "fully" or "substantially" implemented.
 - In 2% of cases, health authorities elected to take "alternative actions". These "alternative actions" also satisfy the OAG's requirements.
- Additional health authority infection prevention and control activities include, but are not limited to:
 - Participation in the Provincial Infection Control Network's surveillance program for *Clostridium difficile* and Methicillin-resistant *Staphylococcus aureus* (MRSA) infections;
 - Ongoing surveillance of hand hygiene compliance rates in all acute care settings, using a provincially-standardized methodology;

- Implementation of clinical best practices for managing antibiotic resistance;
- Implementation of provincial best practice standards for the cleaning, disinfection and sterilization of re-usable medical devices.

S. 13

Program ADM/Division: Heather Davidson, Assistant Deputy Minister, Health Authorities Division
Telephone: (250) 952-1297
Program Contact: Brian Sagar, A/ED, Clinical Care & Patient Safety, (250) 952-2753
Drafter: Catherine Marrie, (250) 952-1730
Date: April 1, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\924298 - Implementation Update OAG's 2007 Infection Control Recommendations for MoH and HAs.docx

Page 126 redacted for the following reason:

S. 13

**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

Cliff #: 927188 (Xref 925390/907573)

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

TITLE: Colorectal Cancer Screening

PURPOSE: To provide information about colorectal cancer screening in BC for the Minister's meeting with the Canadian Cancer Society on May 9, 2012.

BACKGROUND:

- Colorectal cancer is the second leading cause of cancer death for men in British Columbia. The chance of survival is over 90 percent if detected at its earliest stage. Screening not only leads to earlier detection but also to prevention of new cancers by finding and removing high-risk polyps.
- According to the Canadian Cancer Society, BC men and women have the lowest overall incidence and mortality rate for all cancers in Canada, including colorectal cancer.
- In July 2008, the BC Cancer Agency (BCCA), the Provincial Health Services Authority (PHSA), and the Ministry of Health (the Ministry) initiated Colon Check, a population-based colorectal cancer screening pilot.
- The purpose of the pilot was to assess how programmatic, population-based screening could be delivered in the province. The pilot has been underway in Penticton and Powell River since 2009, and in a small area of downtown Vancouver since 2010.
- The BCCA is currently working with the Ministry on developing options for a provincial colorectal cancer screening program.
- In May 2011, the PHSA/ BCCA submitted the Colon Check Action Plan (The Plan). The Plan recommends implementing all aspects of the Colon Check pilot design province-wide, phased in by local health authorities over 5 years.
- The Plan would replace 'Opportunistic' fee-for-service screening, currently provided through a family physician (FP), with a 'Programmatic' model administered and funded by BCCA, for men and women ages 50 to 74. The Plan, as proposed, would alter the provision of medical services to different populations in BC and have significant cost implications for PHSA and the regional health authorities.

DISCUSSION:

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Program ADM/Division: Barbara Korabek ADM, Health Authorities Division,

Telephone: 250 952-1049

Program Contact: Effie Henry, Executive Director

Date: May 7, 2012

Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\927188 - Colorectal Cancer
Screening MO Mtg May 9th w Kaminsky CCS re Colorectal Cancer Screening.doc

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

Page 129 redacted for the following reason:

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S. 17, S. 13

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927612

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

TITLE: Residential Care Regulation Dietitian Requirements

PURPOSE: This document has been prepared for a meeting with
MLA Jane Thornwaite May 17, 2012

BACKGROUND:

The Residential Care Regulation, formerly the Adult Care Regulations (*Community Care and Assisted Living Act*) have changed over the years, and now have an outcome based approach to staffing levels. These changes were made to ensure that the unique care needs of each person in care were assessed and that the appropriate services were provided to each person.

DISCUSSION:

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ADVICE:

S. 13

Program ADM/Division: Barbara Korabek

Telephone: 250.952.1049

Program Contact (for content): Sue Bedford, Director, Community Care Licensing

Drafter: Sue Bedford, Community Care Licensing

Date: May 4, 2012

File Name with Path: A:\HAD General\Briefing Notes\2012\HCIC\927612 MLA Thornwaite May 2012 - approved by Effie Henry obo Barbara Korabek May 11, 2012.doc

Appendix A
Residential Care Regulation:
Provisions regarding nutrition and food services

Food services employees

44 (1) A licensee must ensure that employees responsible for the preparation and delivery of food

- (a) have the experience, competence and training necessary to ensure that food is safely prepared and handled and meets the nutrition needs of the persons in care, and
- (b) receive ongoing education respecting the preparation and delivery of food, nutrition and, if required, assisted eating techniques.

(2) A licensee who accommodates 50 or more persons in care in a community care facility must have, to supervise the preparation and delivery of food, a food services manager who is

- (a) a nutrition manager with membership in the Canadian Society of Nutrition Management,
- (b) a person who is eligible to be a member of the Canadian Society of Nutrition Management, or
- (c) a dietitian.

Division 3 — Nutrition

Menu planning

62 (1) A licensee must ensure that a menu, made in accordance with this section, is developed

- (a) in the case of a community care facility in which persons in care are accommodated for 6 weeks or fewer, for at least each weekly period, or
- (b) in any other case, for at least each 4 week period.

(2) A licensee must ensure that each menu provides

(a) for each day, a nutritious morning, noon and evening meal, with each meal containing at least 3 food groups as described in Canada's Food Guide,

(b) for each day, at least 2 nutritious snacks, with each snack containing at least 2 food groups as described in Canada's Food Guide,

(c) a variety of foods, taking into consideration

(i) the nutrition plan of each person in care and the nutrition needs, age, gender and level of activity of the persons in care,

(ii) the food preferences and cultural background of the persons in care,

(iii) seasonal variations in food, and

(iv) the texture, colour and matters that affect food safety, taste and visual appeal, and

(d) for substitutions to be made that are from the same food group and have a similar nutritional value.

(3) The licensee must take all reasonable steps to ensure that the food served to persons in care follows the menu and, if unable to do so because of unforeseen circumstances, that the food provided to persons in care meets the nutritional requirements set out in subsection (2).

(4) A licensee who provides a type of care described as Long Term Care must display in a prominent place in each dining area the menu for each weekly period.

Food preparation and service

63 (1) A licensee must ensure that all food is safely prepared, stored, served and handled.

(2) A licensee must ensure that food is prepared and served in a manner that, to the extent practicable, is consistent with the personal preferences and cultural background of the persons in care.

(3) A licensee must ensure that meals are provided

(a) in a dining area,

(b) by temporary room tray service, if a person in care is temporarily unable to attend a dining area, or

(c) by ongoing room tray service, if

(i) necessary because of the physical or mental circumstances of the person in care,

(ii) indicated in the care plan of a person in care,

(iii) approved by the person in care's medical practitioner or nurse practitioner, and

(iv) reassessed by the person in care's medical practitioner or nurse practitioner at least once every 30 days.

(4) Without limiting subsection (3) (c), a licensee must ensure that meals are not provided by ongoing room tray service for the convenience of employees.

(5) A licensee must ensure that persons in care have sufficient time and assistance to eat safely and comfortably.

Food service schedule

64 (1) A licensee, other than a licensee who provides a type of care described as Child and Youth Residential, must ensure that

(a) a morning meal is available between 7:00 a.m. and 9:00 a.m.,

(b) a noon meal is available between 11:45 a.m. and 1:00 p.m.,

(c) an evening meal is served after 5:00 p.m., and

(d) snacks are provided at times that meet the needs of the persons in care.

(2) A licensee who provides a type of care described as Child and Youth Residential must ensure that meals and snacks are provided at times that meet the needs of the persons in care.

(3) If preferred by a person in care, a licensee may, despite subsection (1) (a) and (b), provide the person in care with brunch instead of a morning and noon meal on weekends and holidays.

(4) If a person in care is absent during service of a meal or snack, a licensee must provide to the person in care, without charge, a packed meal or snack.

Participation by persons in care

65 (1) A licensee must encourage persons in care to participate in menu planning, meal preparation, food service and related activities as far as is reasonably practical, or as required by a person in care's nutrition plan.

(2) A licensee must ensure that a person in care who is involved in the preparation or service of food is adequately supervised to ensure that the food is safely prepared and handled.

Individual nutrition needs

66 (1) A licensee must ensure that each person in care receives adequate food to meet their personal nutritional needs, based on Canada's Food Guide and the person in care's nutrition plan.

(2) A licensee must ensure that fluids are provided to persons in care in sufficient quantity and variation to meet the needs and preferences of the persons in care.

Eating aids and supplements

67 (1) A licensee must provide each person in care with

(a) nutrition supplements required by the person in care's nutrition plan or ordered by the person in care's medical practitioner or nurse practitioner,

(b) tube feedings ordered by the person in care's medical practitioner or nurse practitioner, and

(c) eating aids, personal assistance or supervision, if required by

(i) a person in care who has difficulty eating, or

(ii) the nutrition plan of a person in care.

- (2) A licensee must ensure that children are not fed by means of a propped bottle.

Short term care plan on admission

- 80 (1) On admitting a person in care to a community care facility, a licensee must ensure that a short term care plan is developed that will guide caregivers in protecting and promoting the health and safety of the person in care.
- (2) Anything that must be recorded in a care plan under this regulation must be recorded in the short term care plan until a care plan is developed.

Care plan needed if more than 30 day stay

- 81 (1) If a person in care is admitted to the community care facility for a period of more than 30 days, a licensee must ensure that a care plan for the person in care is made in accordance with this section within 30 days of admission.
- (2) A care plan must be developed, to the extent reasonably practical,
- (a) with the participation of
 - (i) the person in care, or
 - (ii) if the person in care is not capable of participating, the person in care's parent or representative, and
 - (b) in a manner that takes into account the unique abilities, physical, social and emotional needs, and cultural and spiritual preferences of the person in care.
- (3) A care plan must include all of the following:
- (a) a plan to address
 - (i) medication, including self-administered medication if approved under section 70 (4) *[administration of medication]*,
 - (ii) behavioural intervention, if applicable, and
 - (iii) if there is agreement to the use of restraints under section 74 (1) (b) *[when restraints may be used]*, the type or nature of restraint and the frequency of reassessment;
 - (b) an oral health care plan;

(c) a nutrition plan that

- (i) assesses a person in care's nutrition status, and
- (ii) specifies the nutrition to be provided to the person in care, including the requirements of any therapeutic diets;

(d) a recreation and leisure plan;

(e) in the case of a person in care who receives a type of care described as Long Term Care or who may be prone to falling, a fall prevention plan, which must address

- (i) an assessment of the nature of the risk of falling presented by the person in care,
- (ii) a plan for preventing the person in care from falling, and
- (iii) a plan for following up on any falls suffered by a person in care;

(f) if a person in care has been determined to be at risk of leaving a community care facility without notification of an employee, a plan

- (i) to prevent the person in care from leaving, and
- (ii) if the person in care leaves without notification, to locate the person in care;

(g) if a person in care is a child or youth, any special instruction given in writing by a parent of the child or youth to the licensee;

(h) if a person in care is released on leave under the *Mental Health Act* or is admitted to the community care facility under an enactment or court order, any condition or requirement under the *Mental Health Act*, the enactment or the order associated with the admission of the person in care to the community care facility.

(4) A licensee must ensure that

(a) the implementation of each care plan is monitored on a regular basis to ensure proper implementation,

- (b) each care plan is reviewed and, if necessary, modified
 - (i) if there is a substantial change in the circumstances of the person in care, or
 - (ii) if there is no substantial change in the circumstances of the person in care, at least once each year.

to ensure it continues to meet the needs and preferences, and is compatible with the abilities, of the person in care who is the subject of the care plan, and

- (c) to the extent reasonably practical, persons in care participate in the review and modification of their own care plans.

Implementation of care plans

82 A licensee must ensure that the care and supervision of a person in care is consistent with the terms and conditions of the person in care's care plan.

Nutrition plan

83 (1) A licensee of a community care facility with 24 or fewer persons in care must

- (a) develop a nutrition plan for each person in care, and
- (b) if a nutrition plan is developed without the assistance of a dietitian, ensure that reasonable steps are taken to assess the specific nutritional needs of the person in care who is the subject of the nutrition plan, including considering whether the person in care is at risk of being inadequately nourished because of
 - (i) a physical or mental condition,
 - (ii) a history of issues that affect eating by the person in care, or
 - (iii) any other relevant factor.

(2) A licensee of a community care facility with more than 24 persons in care must develop, with the assistance of a dietitian, a nutrition plan for each person in care.

(3) A licensee must review the nutrition plan of a person in care as follows:

- (a) in the case of a nutrition plan developed under subsection (1), on a regular basis,
- (b) in the case of a nutrition plan developed under subsection (2), with a dietitian on a regular basis, and
- (c) in any case, with a dietitian if requested or required by
 - (i) a health care provider who provides care to the person in care,
 - (ii) a medical health officer, or
 - (iii) a funding program.

(4) Subject to subsection (5), a licensee, other than a licensee who provides a type of care described as Hospice, must

- (a) ensure that each person in care is weighed at least once each month,
- (b) immediately seek the advice of a health care provider if the person in care has experienced, unintentionally, a significant change in weight, and
- (c) record the weight in the nutrition plan of the person in care.

(5) If a person in care refuses or is unable to be weighed, the licensee must

- (a) record in the nutrition plan of the person in care the reason why the person in care was not weighed, and
- (b) if it appears to the licensee that the person in care may have experienced a significant change in weight, immediately seek the advice of a health care provider.

Food services record

87 A licensee must keep a record of the following matters respecting food services:

- (a) food purchases;
- (b) menus and menu substitutions;

(c) the results of monitoring, by the licensee, of food services and nutrition care;

(d) food services and nutrition care education and training programs attended by food services employees.

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927783

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

TITLE: B&W MRI Services, Ltd.

S. 13, S. 21, S. 17

Page 144 redacted for the following reason:

S. 13 s. 17 s. 21

Appendix A¹

Contracts with providers must include provisions addressing the following:

- Service specifications (type of service being purchased, volume of service being purchased per week or month);
- Total cost per service and funding ceilings;
- Details of ownership and control of business decisions in private facility, including provisions regarding transfer of ownership;
- Location where services are to be provided;
- Duration of contract;
- Requirement of private facilities to:
 - Be accredited by the College of Physicians and Surgeons as non-hospital medical or surgical facility;
 - Have a quality assurance process in place that meets standard of practice;
 - Comply with health authority policy;
 - Comply with the relevant provincial and federal legislation; and
 - Have sufficient insurance;
- Requirement that health professionals working in private facilities be licensed in good standing with the appropriate professional college;
- Requirement that physicians working in private facilities be a member of the Regional Medical Staff (or on contract with health authority);
- Performance measures (e.g., mortality rates, complication rates, wait times) and reporting mechanisms;
- Right for health authority to inspect or audit the facility, equipment, personnel and records with respect to monitoring of contract;
- Indemnification of health authority from liability for patient care;
- Reporting requirements;
- Penalties for interruption of services; and
- Non-expropriation provisions.

¹ Policy Communiqué # 2002-37, *Patient Service Delivery Policy Framework*

**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

928561

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

TITLE: Release of Vancouver Coastal Health Authority (VCHA) Internal Review of Transgender Health Program (THP) to its Advisory Group.

PURPOSE: To provide a summary of VCHA's internal report and advise the Minister of its impending release.

BACKGROUND:

Services for the transgendered population in British Columbia are currently concentrated in Vancouver within VCHA. This population has higher than normal suicide and suicide attempt rates, and is more likely to be living in poverty (see Appendix One).

THP is not a clinical program but rather provides support and assistance to anyone with a transgender health question (transgender people, youth, loved ones, health care providers, etc.) by offering information, resources and short term support. The annual budget for THP is \$160,000.

In September 2011, an internal review of the THP was commissioned by VCHA. The aim of the review was to gather information about the strengths and challenges of the THP, as well as to identify opportunities for strategic planning and implementation over the next five years. This report presents 15 high-level recommendations arising from the review process (Appendix Two contains the recommendations; Appendix Three is the full report).

DISCUSSION:

Other health authorities are aware that there may be minor funding implications as a result of the recommendations, mostly in the mental health/community sector in future years. However, as this population is already accessing services, more knowledge of the needs of this community may result in better care and potentially less expenditures as needs are better addressed.

Other health authorities support the release of the report to the advisory group. A draft was presented to the Health Operations Committee on May 11, 2012, and there were no major concerns expressed.

FINANCIAL IMPLICATIONS:

There are no direct financial implications of releasing the report to the advisory group.

VCHA is making short-term changes to improve the program within the current budget and working to secure additional funding (e.g. developing a business case and exploring new partnerships) to implement longer-term recommendations.

There may be some financial implications for other health authorities in fiscal years 2013/14 and beyond, mostly in the mental health/community sector. The Ministry of Health will monitor and assess these financial implications as more detailed information becomes available.

ADVICE:

It is recommended that VCHA release the report to its advisory group.

Program ADM/Division:	Effie Henry, A/ADM, Health Authorities Division
Telephone:	250-952-1049
Program Contact (for content):	Kirk Eaton, A/Executive Director – Hospital and Provincial Services
Drafter:	Nancy South
Date:	May 17, 2012
File Name with Path:	Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\HAD\928561 - THP review release to AdvisoryGroup.docx

Appendix One:

Transgendered Health Program – Quick Facts from VCH Literature Review

1. Estimated size of trans population

- Currently, there are no reliable epidemiological studies on the incidence/prevalence of transgendered people.
- Estimates in Western adult populations vary significantly based on definitions and study methodology; for the sake of discussion here, it is assumed that 0.1 % to 1.0 % of the adult population is transgendered.
- All numbers show an **increasing trend**.

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3. Poverty Rates for the Transgendered Population (study in Ontario)

- 50% had personal annual income less than \$15,000
- 21% incomes under \$30,000
- Discrimination by employers is major issue

Because many forms of care needed by transgendered people are only available privately, many cannot access the services they need. Families may be financially stressed in supporting transgendered youth by paying for private care needs.

4. High rates of violence and stigma

- Transgendered people are more prone to violent physical and sexual assaults.
- Transgendered victims of violence have a four-times higher rate of suicide attempts than other transgendered people.

Pages 150 through 180 redacted for the following reasons:

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**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

Cliff # 912943

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

TITLE: January 5, 2012 P/T Health Ministers teleconference

PURPOSE: To discuss how P/T Health Ministers will respond to the Federal Health Minister's proposed bi-lateral meetings.

BACKGROUND:

On December 19, 2011 at the Federal/Provincial/Territorial (F/P/T) Finance Ministers of Health meeting, the federal Finance Minister announced changes (the Announcement) to the Canada Health Transfer (CHT) along with other fiscal arrangements (i.e. CST and Equalization). The announced changes were done unilaterally without any P/T input or consultations.

The CHT will continue to grow at 6 percent for an additional three years beyond 2013/14 (i.e. 2014/15, 2015/16 and 2016/17). In 2017/18, however, the CHT will grow in line with a 3 year moving average of nominal GDP growth, with funding guaranteed to increase by at least 3 percent per year.

Most jurisdictions expressed concerns with the lack of consultation prior to the Announcement and the size of the CHT escalator. For example, with the CHT reduction and move to per capita funding, British Columbia (BC) could lose as much as \$250 million per year.

On December 20, 2011 the Federal Health Minister, Leona Aglukkaq, sent a letter to P/T Health Ministers proposing to work with them on accountability and escalating costs (Attachment A). The letter suggests F/P/T health ministers "re-engage in the New Year" to "start work on an approach to measuring and reporting performance across health systems using common metrics". Upon analyzing the content of the letter, officials believe that the Federal Health Minister's proposed approach for collaboration go beyond what was agreed at the F/PT Health Ministers' Meeting in November (HMM). Moreover, the HMM discussions were made in the context of and in anticipation of negotiating a new health accord.

Recently, the Federal Health Minister told the media that the federal government still has influence with provinces on health policy despite issuing a new funding formula without conditions. She indicated she will be travelling in January 2012 to meet with her provincial counterparts and lay the groundwork for talks about how health care standards should be improved after the current accord expires in 2014. In particular, she wants to discuss with her colleagues issues related to performance measurement, accountability and sharing of best practices rather than money.

Thus far, BC, NL, and SK have been approached to arrange bilateral meetings. As the NL Health Minister is confirmed to meet with Minister Aglukkaq on January 11, 2012, Nova Scotia would like to understand how each jurisdiction will approach these bilateral discussions and possibly come up with a common P/T position in engaging the federal government. BC and SK have not yet confirmed their participation in proposed bilateral discussions with the federal government.

Discussions on the sustainability of the health system and fiscal arrangements will occur at the upcoming Council of the Federation meeting on January 16/17. Most jurisdictions have indicated that they will wait for the Premier's discussions and directions on whether to meet with the Federal Health Minister or respond to her letter.

DISCUSSION:

The announcement on fiscal arrangements represents a significant departure from collaborative federalism. Although P/Ts recognize the value and predictability of the federal investment, some jurisdictions are not convinced these investments are balanced and sustainable enough to resolve the funding issue.

Also, the Announcement was entirely around funding without conditions or strings attached. As a result, it is unclear why the Federal Minister of Health believes she has the mandate to engage jurisdictions in working together on accountability and measuring and reporting performance based on common metrics. The federal government has pre-empted these discussions with its Announcement, and made it clear it is not interested in negotiating a new health agreement.

In approaching the bilateral discussions with Minister Aglukkaq, the PT Ministers of Health have two options, which could be nuanced depending on the circumstances: take a jurisdictional approach developed in consultation with the premier and finance offices; or develop a common PT approach in responding.

A jurisdictional approach will enable BC to pursue its strategy on calling for a demographic adjustment to equal per capita cash CHT and being recognized for its health innovation and change agenda. By taking this approach, BC risks further isolation when engaging in PT led initiatives for health.

A common PT approach will see jurisdictions pushing back strongly on the Federal Minister of Health's attempt to use back door maneuvering to attach conditions to the CHT funding. BC could position itself as a leader in developing a national innovation agenda with performance measure and an accountability mechanism for its implementation.

CONCLUSION:

BC should develop its own strategy for engaging in bilateral discussions with the Federal Minister. BC would, however, support developing a common P/T position to such discussions with the Federal Minister following the January 2012 COF meeting if the outcomes of that meeting warrant such an approach.

Program ADM/Division:	Michael MacDougall, Chief Operating Officer
Telephone:	952-1764
Program Contact:	Mariana Diacu, Intergovernmental Relations Branch
Drafter:	Michael Kary
Date:	January 5, 2012
Attachments:	Annex B – December 20, 2011 letter from Federal Health Minister
File Name with Path:	

Fax Transmittal

To:	All P/T Ministers of Health / Aux ministres PT de la Santé
c.c.	P/T Deputy Ministers of Health / Sous-ministres PT de la Santé
Date:	December 20, 2011 / le 20 décembre 2011
Subject/ Object :	Health system renewal and accountability / Renouvellement du système de santé et reddition des comptes
Pages:	4 including cover / 4 pages avec la page titre



DEC 20 2011

Ottawa, Canada K1A 0K9

Dear colleagues:

I am writing to follow up on our recent meeting in Halifax where we discussed priorities and challenges in health system renewal.

During our discussions, we agreed that as Health Ministers, our focus should be on approaches to improving the health of Canadians and our health care system, and that issues related to the future of fiscal transfers should be left for Ministers of Finance to discuss.

As you know, Ministers of Finance met yesterday in Victoria, and following these discussions, we now have certainty and stability around future levels of the Canada Health Transfer and other major federal transfers. My colleague, the Honourable Jim Flaherty, Minister of Finance, announced a major investment in health care that will see federal funding for health care continue to increase to record levels. This investment is balanced and sustainable, and provides a solid foundation for further progress on health system renewal to ensure the health care system will be there when Canadians need it. This investment also provides the opportunity to put the divisive issue of funding behind us to allow us all to focus on the real issue – how to improve the system so you can ensure timely access to health care when needed.

I understand that provincial and territorial leaders are meeting in mid-January to discuss health care. I look forward to hearing the outcome of this discussion and would suggest that F-P-T Health Ministers re-engage in the New Year to further map out how we can work together to make Canada's health system more sustainable, to improve accountability and to get better results for Canadians. Building on our discussion in November, we could consider tasking our officials to start work on an approach to measuring and reporting performance across health systems using common metrics.

I have asked my officials to work with yours over the coming weeks to discuss next steps and propose an approach for moving forward.

Sincerely,

Leona Aglukkaq

Canada



DEC 20 2011

Chers collègues,

Je vous écris pour donner suite à notre récente rencontre, à Halifax, où nous avons discuté des priorités et des défis liés au renouvellement du système de santé.

Pendant ces discussions, nous avons convenu qu'à titre de ministres de la Santé, nous devrions nous concentrer sur les approches visant à améliorer la santé des Canadiens et notre système de soins de santé, et qu'il fallait laisser aux ministres des Finances le soin de discuter des questions relatives à l'avenir des transferts fiscaux.

Comme vous le savez, les ministres des Finances se sont rencontrés hier à Victoria et, suite aux discussions, nous avons maintenant une certitude et une stabilité en ce qui concerne les futurs niveaux du Transfert canadien en matière de santé et d'autres importants transferts fédéraux. Mon collègue, l'honorable Jim Flaherty, ministre des Finances, a annoncé un investissement majeur dans les soins de santé, qui continuera à porter le financement fédéral des soins de santé à des niveaux record. Cet investissement est équilibré et durable, et il constitue une base solide à partir de laquelle il sera possible de continuer à renouveler le système de santé pour que les Canadiens puissent compter sur le système lorsqu'ils en ont besoin. Cet investissement permettra aussi de mettre derrière nous la question controversée du financement, ce qui nous permettra à tous de nous concentrer sur le véritable enjeu – comment améliorer le système afin de garantir un accès rapide aux soins de santé lorsqu'ils sont nécessaires.

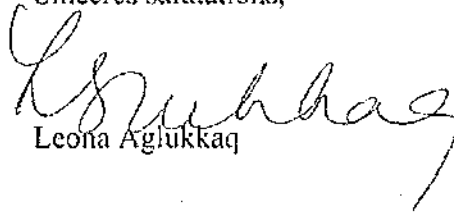
Je crois comprendre que les dirigeants provinciaux et territoriaux se rencontreront à la mi-janvier pour discuter des soins de santé. Je me réjouis de connaître le résultat de cette discussion et je me permets de suggérer que les ministres F-P-T de la Santé cherchent à nouveau au cours de la nouvelle année à préciser comment nous pouvons travailler ensemble pour rendre le système de santé du Canada plus durable, pour en améliorer la reddition de comptes et pour obtenir de meilleurs résultats à l'intention des Canadiens. Sur la base de notre discussion du mois de novembre, nous pourrions envisager de confier à nos fonctionnaires la tâche de commencer à travailler à une approche qui permettrait de mesurer le rendement de tous les systèmes de santé et d'en faire rapport, à partir d'indicateurs communs.

.../2

- 2 -

J'ai demandé à mes fonctionnaires de travailler avec les vôtres au cours des prochaines semaines pour discuter des prochaines étapes et proposer une approche.

Sincères salutations,

A handwritten signature in dark ink, appearing to read 'Leona Aglukkaq', written in a cursive style. The signature is positioned above the printed name.

Leona Aglukkaq

Participants
PT MINISTERS OF HEALTH
Conference Call
January 5, 2012
(Jan 4, 2011)

JURISDICTION	MINISTER	
NOVA SCOTIA – Health & Wellness	Maureen MacDonald	Yes
BRITISH COLUMBIA	Michael de Jong	Yes
ALBERTA	Fred Horne	ADM Susan Williams confirmed to take the call
SASKATCHEWAN	Don McMorris	
MANITOBA - Health Healthy Living	Theresa Oswald Jim Rondeau	DM Sussman Confirmed to take the call
ONTARIO - Health & Long Term Care	Deb Matthews	
QUEBEC	Yves Bolduc	
NEW BRUNSWICK - Health Wellness, Culture & Sport	Madeleine Dubé Trevor Holder	Yes
PRINCE EDWARD ISLAND	Doug Currie	Yes
NEWFOUNDLAND AND LABRADOR	Susan Sullivan	
YUKON	Doug Graham	Yes
NORTHWEST TERRITORIES	Tom Belliveau	Yes
NUNAVUT	Keith Peterson	Yes

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 914749

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

TITLE: Lower Mainland Pathology and Laboratory Medicine Staff Transfer

PURPOSE: To provide the Minister with a status update regarding scheduled staff transfer activities in Pathology and Laboratory Services (PLS), under the Lower Mainland Consolidation Initiative.

BACKGROUND:

MoH and the Lower Mainland health organizations (FH, PHC, PHSA, VCH) initiated Lower Mainland Consolidation (LMC) in August 2009 to support health system sustainability.

PHSA has leadership responsibility for the consolidated Pathology and Laboratory Services. The intention to transfer unionized laboratory staff from the other participating health organizations into PHSA to create to a single laboratory enterprise has been a stated part of the approved laboratory plan from the beginning. Transfer of excluded Pathology and Laboratory Services staff was completed in April 2011.

On January 16, 2012, the Lower Mainland Consolidation Steering Committee approved the request to proceed with Section 54 notification and commence the process of transferring unionized staff.

DISCUSSION:

There will be 1256 FTEs in-scope for the transfer. This is comprised of both full- and part- time employees, meaning the number of impacted employees will be approximately 2000 (1500 staff and 500 casual). These employees are represented by the Health Sciences Association and Health Employees Union.

The transfer changes employer relationship only. It does not impact medical oversight.

Benefits:

The goals attributed to the negotiation will be:

- Improve Quality through further standardization of operating procedures and quality framework for lab operations
- To move to a single seniority list for laboratory
- Change staff mix to maximize the use of Medical Laboratory Assistants where appropriate
- Streamline and standardize the HSA organization structures
- To centralize the call centers for PHSA, VCH and PHC
- Balance workload and staff to leader ratios
- Create additional front line positions to address workload
- Reduce variation among position classification

Lower Mainland health organizations strongly encourage this transfer as the changes are expected to enhance opportunities for savings and should realize between \$800,000 to \$1.2 million in savings.

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Timing:

Section 54 notification will proceed within 2 weeks. Once the discussions are concluded with IISA (60 days) and HEU (90 days) laboratory operations will execute on the plan to transfer as soon as is feasible.

Program ADM/Division: Michael MacDougall, Chief Operating Officer

Telephone: 250-952-1764

Program Contact: Sandra Maxson, Director, Strategic Initiatives

Date: January 17, 2012

File Name with Path: Z:\Deputy Minister\Briefing Documents\2012\Lab Staff Transfer IBN January 2012.doc

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 926739

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

TITLE: Minister Meeting with Health Sciences Association President Reid Johnson

PURPOSE: To provide background on the Health Sciences Association and the issues HSA intends to raise with Ministers/MLAs on their April 30, 2012 Lobby Day.

BACKGROUND:

The Health Sciences Association (HSA) is the largest constituent union in the Health Sciences Professionals Bargaining Association (HSPBA), representing approximately 13,300 employees. The HSA also represents 725 employees in the Nurses Bargaining Association and 560 employees in the Community Bargaining Association

The HSA includes a diverse range of paramedical professions (376 classifications), for example, physiotherapists, occupational therapists, medical technologists and social workers, working predominantly in acute care facilities, with a small percentage also working in community settings. Approximately 89% of HSPBA members are employed by the province's six health authorities and 11% by affiliate organizations.

The Health Employers Association of BC (HEABC) and the HSPBA are currently at the bargaining table negotiating a renewed collective agreement. The current HSPBA Collective Agreement expired on March 31, 2012 but remains in force while bargaining continues. Negotiations are taking place in the context of the government's 2012 Cooperative Gains bargaining mandate which allows for modest wage increases or other employee improvements if savings can be achieved without reducing services or transferring costs to the public.

The current HSPBA Collective Agreement provides for a Joint Strategic Partnership Committee (JSPC) made of up senior level representatives from the HSPBA, each of the health authorities (HAs), Ministry of Health (MOH) and the Health Employers Association of BC (HEABC). The JSPC's agenda includes improvements to utilization of health human resources, service delivery and quality and sustainability of the health care system.

Pages 191 through 193 redacted for the following reasons:

S. 13

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff: 917331

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

TITLE: 2012 Summit on Positive Mental Health

PURPOSE: Information about the summit, February 15-16, 2012, Winnipeg, MB

BACKGROUND:

Following the July 2011 Council of the Federation meeting, the Premiers' *Focus on Families* communiqué highlighted the importance of promoting positive mental health and preventing mental illnesses. Accordingly, Manitoba agreed to host a national summit on positive mental health, scheduled for February 15-16, 2012, in Winnipeg.

The summit will include a combination of formal presentations and knowledge exchange workshops (draft agenda attached as Appendix A), as well as opportunities for ministers to privately discuss issues and opportunities.

The overarching goals of the event are to:

- share evidence on effective cross-sectoral mental health promotion and mental illness prevention across the lifespan, with an emphasis on children and youth;
- improve the collective knowledge base and related actions of governments and stakeholders across Canada; and
- discuss mechanisms for ongoing work and collaboration of governments and stakeholders after the summit.

In addition to invited ministers, each province/territory has been encouraged to send a summit delegation that includes involved ministries, researchers and community experts.

British Columbia has assembled a delegation that reflects expertise in positive mental health across sectors, settings and the life span—Appendix B lists BC's confirmed delegates.

DISCUSSION:

BC's recently released 10-year plan (the Plan) to address mental health and substance use—*Healthy Minds, Healthy People*—lays out a transformational cross-government, multi-sector approach, and identifies 6 provincial milestones for achievement. The Plan calls for an expanded upstream response that promotes positive mental health, prevents mental illness, and intervenes early when necessary. Taken together, the Plan's goals and actions aim to improve the health and wellbeing of all British Columbians, contain growth in the burden of mental illness and substance use problems, and contribute to health system sustainability. *Healthy Minds, Healthy People* focuses on opportunities to promote positive mental health at home, at school and at work, and emphasizes the importance of ensuring healthy early development by reaching and supporting infants, children, youth and their families. A first year *Healthy Minds, Healthy People* progress report will be available in time for the summit.

As outlined in the *Healthy Minds, Healthy People* progress report, we are breaking new ground in BC and leading the country by example through initiatives such as:

- implementing the **Nurse-Family Partnership** program across the province;
- expanding the **FRIENDS For Life** program in BC's schools;
- promoting positive mental health for university/college students through the **Healthy Minds, Healthy Campuses** project;
- introducing the **Public Service Agency Workplace Mental Health** initiative; and
- developing an **Elder Abuse Prevention** strategy.

Further information about these examples is contained in Appendix C. Additionally, *Healthy Minds, Healthy People* outlines a "whole system" response that is fully aligned with BC's Health System Innovation and Change Agenda (see Appendix D).

Moving upstream to promote positive mental health and prevent mental illness requires a comprehensive approach—just like addressing physical health issues. The summit provides a strategic opportunity to secure complementary support for provincial efforts from key national partners by:

- encouraging the **Mental Health Commission of Canada** to ensure its forthcoming National Mental Health Strategy places the positive mental health of all Canadians and the sustainability of provincial health systems front and centre. The Commission has asked to meet with the Minister of Health in Winnipeg (see Appendix E for a copy of the Meeting Advice form 917054, separately routed);
- encouraging the **Public Health Agency of Canada** to expand its efforts on positive mental health through Canada's Healthy Living Strategy; and
- encouraging the **Canadian Institutes of Health Research** to ensure Canada's mental health research agenda moves upstream and contributes to health system sustainability and positive mental health for all.

ADVICE:

The national Mental Health Summit is a strategic opportunity to reaffirm and profile BC's leadership in promoting positive mental health. There is a complementary opportunity to influence the national mental health promotion agenda. A meeting with the Mental Health Commission of Canada would help ensure their forthcoming national strategy is aligned with BC priorities. With better alignment from federal and national partners, BC's capacity to achieve the transformative vision established in *Healthy Minds, Healthy People* would be enhanced, strengthening our ability to reach the milestones for achievement established in BC's plan.

Program ADM/Division: Arlene Patton, ADM, Population Public Health Division

Telephone: (250) 952-1731

Program Contact: Warren O'Briain, Executive Director, Communicable Disease Prevention, Harm Reduction and Mental Health Promotion

Drafter: Stephen Smith, Director, Mental Health Promotion & Mental Illness Prevention

Date: February 6, 2012

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Mental Health Summit 2012

Mental Health Promotion and Mental Illness Prevention for All

February 15-16, 2012 • Winnipeg, Manitoba

PRELIMINARY AGENDA (January 31 Version)

February 14, 2012 Location: Fort Garry Hotel, 222 Broadway Avenue, Winnipeg, MB

Time	Session
4:15 – 9:30 pm	Early Registration

February 15, 2012 Location: Fort Garry Hotel, 222 Broadway Avenue, Winnipeg, MB

Time	Session
7:00 – 10:00 am	Breakfast and Registration
8:30 – 9:00 am	Introduction of HCCC Minister by Master of Ceremonies – Jan Sanderson (Deputy Minister; Children and Youth Opportunities, Secretary to Healthy Child Committee of Cabinet; CEO Healthy Child Manitoba Office) Elder Blessing Introduction (by HCCC Minister) of The Honourable Greg Selinger, Premier of Manitoba Welcome – The Honourable Greg Selinger, Premier of Manitoba
9:00 – 10:15 am	Introduction of Keynote Speaker Opening Keynote – Dr. Lynne Friedli, World Health Organization (WHO) Europe (confirmed) "The (equal) chance of a life well lived: Acting on the social determinants of mental health and well-being"
10:15 – 10:45 am	Refreshment Break
10:45 – 12:00 pm	Introduction of Keynote Address Keynote Address – Dr. Carl Bell, Institute of Medicine (IOM) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults "Prospects for the Prevention of Mental Illness: New Developments and New Challenges"
12:00 – 1:00 pm	Lunch and entertainment *Private Ministers and DMs lunch with select international speakers: an opportunity for Ministers, DMs and Speakers at the conference to meet and network. Ministers and DMs will have the opportunity to ask questions of the expert Speakers. The lunch will be hosted by a MB Minister, to

A partnership of:

Manitoba Children and Youth Opportunities (Chair) • Manitoba Healthy Living, Seniors and Consumer Affairs • Manitoba Aboriginal and Northern Affairs • Manitoba Culture, Heritage and Tourism • Manitoba Education • Manitoba Family Services and Labour/Status of Women • Manitoba Health • Manitoba Housing and Community Development • Manitoba Justice • Manitoba Immigration and Multiculturalism



Mental Health Summit 2012

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	be confirmed.
1:00 – 2:15 pm	Concurrent Sessions 1. Non-pharmaceutical behavioural vaccines and evidence-based kernels for the promotion of well-being and the prevention of mental and related illnesses (Dr. Dennis Embry) 2. Toward a national mental health strategy (Mental Health Commission of Canada) 3. Flourishing for all: Mental Health Promotion and Mental Illness Prevention for Canadians (Pan-Canadian Steering Committee for Mental Health Promotion and Mental Illness Prevention – Co-Chairs: Marion Cooper, MB, and Beth Evans, AB) 4. Comic books as mental health knowledge transfer tool with children and youth (Sean Muir) 5. The public health priority of mental health promotion and mental illness prevention (Dr. Charlotte Waddell) (*2 sessions if needed) 6. Promoting culture promotes health: The case of First Nations youth suicide (Dr. Chris Lalonde) 7. The economic return of investment from mental health promotion and mental illness prevention (Dr. Glen Roberts) 8. Workplace mental health (Mary Ann Baynton, Great West Life, MHCC) 9. Truth and Reconciliation Commission (Justice Sinclair, Chair)
2:15 – 2:30 pm	Refreshment Break
2:30 – 3:45 pm	Concurrent Sessions (continued) – additional speakers and topics, including dementia prevention 10. Promoting recovery from intractable mental, emotional, behavioural and related disorders using evidence-based kernels (Dr. Dennis Embry) 11. Towards Flourishing – Mental Health Promotion for Families: A Public Health Agency of Canada Mental Health Promotion Innovation Strategy project (Jennifer Volk and Dr. Mariette Chartier) 12. Toward a national mental health strategy (Mental Health Commission of Canada) 13. Comic books as mental health knowledge transfer tool with children and youth (Sean Muir) 14. The public health priority of mental health promotion and mental illness prevention (Dr. Charlotte Waddell) (*2 sessions if needed) 15. Joint Consortium on School Health (Katherine Eberl Kelly) 16. Alzheimer's (speaker unconfirmed) 17. Poverties and Gifts: A holistic perspective on mental health promotion and mental illness prevention (Dr. Madeleine Dion Stout) 18. The epigenetics of mental health and obesity (Dr. Stephen Lye)

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3:45 – 4:15	Reflection on the Day (Ministers from across Canada)
4:15 – 5:30 pm	Poster and Resource Displays – Cheese and Crackers (background music)
5:30 – 8:30 pm	Dinner (advanced tickets only) – Fort Garry Place, 85 Garry Street, Winnipeg, MB (background music)
6:00 – 7:00 pm	Welcome - HCCC Minister (to be determined) Banquet Blessing – Karen Toole, Provincial Spiritual Health Care Coordinator for Manitoba Dinner served
7:15 – 8:15 pm	Panel on Whole-of-Government Approaches and Economic Impact of Mental Health Promotion and Mental Illness Prevention – Chair: Dr. David Butler Jones, Chief Public Health Officer of Canada
8:15 pm	Closing Remarks

February 16, 2012 Location: Fort Garry Hotel, 222 Broadway Avenue, Winnipeg, MB

Time	Session
7:30 – 8:30 am	Breakfast
8:30 – 9:00 am	Opening and Introduction of HCCC Minister (To be confirmed) by Jan Sanderson Introduction of Minister Aglukkaq by HCCC Minister Welcome – Honourable Leona Aglukkaq, Minister of Health, Government of Canada (tentative)
9:00 – 9:15 am	Introduction of Louise Bradley by HCCC Minister (To be confirmed) Opening comments – Louise Bradley, Mental Health Commission of Canada
9:15 – 10:30 am	Introduction of Facilitated Session by Lillian Bayne Facilitated Session – Mental Health Promotion and Mental Illness Prevention Across Canada – PART I: Small Group Discussions By Sector/ Area of Practice

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	Building on knowledge gained from Day 1, participants will be asked to break into groups by individual sector (e.g. education, justice, health, etc.) to discuss from a systemic perspective how mental health promotion (MHP) and mental illness prevention (MIP) applies to the work within their sector; in what ways MHP and MIP can be moved forward within their area of practice/policy; and to identify key concepts for moving forward.
10:30 – 10:45 am	Refreshment Break
10:45 – 12:00	PART I (continued): Small Group Sessions by Province/Territory By Jurisdiction (Province/Territory/Federal/Aboriginal/National) Building on knowledge gained from Day 1 and early morning discussions, participants will be asked to break into groups by Jurisdiction to discuss from a systemic perspective how mental health promotion (MHP) and mental illness prevention (MIP) practice and policy can be moved forward across sectors and to identify key concepts for moving forward.
12:00 – 1:00 pm	Lunch and entertainment Private Ministers only lunch and meeting – an opportunity for Ministers attending the conference to reflect on the conference and the cross-sectoral approach to mental health promotion and mental illness prevention. This is not a formal PT or FPT Ministerial lunch, there will be no common messaging or press release. The lunch will be hosted by a MB Minister, to be confirmed.
1:00- 1:15 pm	Welcome – HCCC Minister, Government of Manitoba
1:15 – 2:15 pm	Closing Keynote Address – Professor Clyde Hertzman, University of British Columbia (confirmed) "Mental Health Promotion and Mental Illness Prevention for All: An Evidence-Based Call to Action"
2:15 – 2:30 pm	Refreshment Break
2:30 – 4:00 pm	Summary of Facilitated Sessions – by Lillian Bayne Large group facilitated discussion Compilation of Summit outcomes
4:00 – 4:30 pm	~~Reflection on the Day (Ministers)~~ Thanks and Farewell – Jan Sanderson

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2012 Mental Health Summit (February 15-16): British Columbia Delegation
(list current as of February 7, 2012):

BC Delegation Meetings

- 1) Wednesday, Feb 15th - 7:45 am. Orientation and introductions (location TBD)
- 2) Thursday, Feb 16th - 7:45. Mid-way sharing of observations (location TBC)
- 3) Thursday, Feb 16th - 10:45 - 12:00 - part of the Summit's second day agenda:
 - discuss from a systems perspective how mental health promotion and mental illness prevention practice and policy can be moved forward across sectors; and
 - identify key concepts for moving forward.

1. Honourable Michael De Jong, Minister of Health, British Columbia
2. Ms. Shazia Rana, Executive Assistant to Minister de Jong, Ministry of Health, British Columbia
3. Ms. Arlene Paton, Assistant Deputy Minister, Population and Public Health, Ministry of Health
4. Ms. Paige MacFarlane, Assistant Deputy Minister, Partnerships and Planning, Ministry of Education
5. Mr. Warren O'Briain, Executive Director, Communicable Disease Prevention, Harm Reduction and Mental Health Promotion, Ministry of Health
6. Ms. Sandy Wiens, Executive Director, Child Welfare and Child and Youth Mental Health Policy, Ministry of Children and Family Development
7. Mr. Ron Duffell, Director, Healthy Minds, Healthy People Directorate, Ministry of Health
8. Ms. Charito Elderfield, Manager, Families First, Ministry of Education
9. Ms. Olga O'Toole, Child and Youth Mental Health, Ministry of Children and Family Development, Coast Fraser Region
10. Ms. Michelle De Groot, Executive Director, Health Actions, First Nations Health Council & Chair, Tripartite Mental Wellness & Substance Use Strategy Council

11. Mr. Jonny Morris, Director, Mental Health Promotion, Canadian Mental Health Association BC/Yukon Division
12. Mr. Rick Price, School Trustee SD 48, Former Chairperson, Sea-to-Sky Communities that Care Action Committee
13. Dr. Kim Schonert-Reichl, Associate Professor, Department of Educational and Counselling Psychology and Special Education, University of British Columbia
14. Dr. Bernadette Pauly, Associate Professor, School of Nursing, University of Victoria
15. Dr. Merv Gilbert, Consortium for Organizational Mental Healthcare, Simon Fraser University

Additional BC participants invited directly by the summit:

1. Dr. Clyde Hertzman, Professor, Population and Public Health & Director, Human Early Learning Partnership, University of British Columbia
2. Dr. Charlotte Waddell, Associate Professor, Health Sciences & Director, Children's Health Policy Centre, Simon Fraser University

Action in BC to Promote Positive Mental Health & Prevent Mental Illnesses

Nurse-Family Partnership Program

The Ministry of Health and Ministry of Children and Family Development are collaborating with BC's health authorities, research partners at Simon Fraser and McMaster Universities, and other health and social service partners to launch the Nurse-Family Partnership program across BC in early 2012. This program will be offered to young, low-income, pregnant women who will be mothers for the first time, a group that often faces significant challenges related to healthy parenting. Participating mothers receive frequent supportive home visits from public health nurses starting early in pregnancy, and continuing until their child turns two. The program supports healthy infant development, and improves the mental and physical health and well-being of mothers and children for years after their participation. Careful implementation and scientific evaluation will ensure the NFP program is appropriately adapted for the BC context, is consistently delivered across the Province's health authorities, and achieves the same outcomes as demonstrated in other jurisdictions.

FRIENDS for Life Program

The FRIENDS for Life program is a school-based, early intervention and prevention program that reduces the risk of anxiety disorders and builds resilience in children. The Ministry of Children and Family Development (MCFD) brought FRIENDS to BC in 2004, as part of the five-year BC Child and Youth Mental Health Plan (2003-2008). In order to reach as many children and youth as possible, BC has made FRIENDS available to all grade four to seven students in the province through a partnership between MCFD and schools. Recent program enhancements include provincial implementation of "Fun FRIENDS" for kindergarten and grade one students. The FRIENDS parent component includes in-person and new online parent workshops and resources. Program materials have been adapted to be more culturally relevant for Aboriginal students. To date, more than 4,000 BC teachers and educators have completed the required one-day teacher training. All public school districts (60) have participated in the training and classroom delivery, including many independent schools and First Nations schools.

Healthy Minds, Healthy Campuses Project

This project leverages a province-wide network comprised of students, campus professionals, faculty, and administrators. Established in 2004, the network has grown into a vibrant and diverse virtual "community of practice" including representation from 20 post-secondary institutions in BC. Project activities enhance understanding and capacity to promote positive mental health, reduce harmful substance use, and prevent suicide on BC campuses. Drawing from available evidence and best practices, network members are engaged in developing and implementing campus-specific policies that positively influence mental health and substance use, and working together to shape health-promoting campus environments.

Public Service Agency Workplace Mental Health Initiative

The BC Public Service Agency is preparing to launch a multi-component initiative to support the mental health of public service employees. The initiative will increase awareness of workplace-based mental health promotion approaches and actions, build broader understanding of the early

warnings signs of a potential mental health problem, and facilitate supportive environments for those returning to work after an absence due to mental illness or a substance use problem. The initiative is intended to positively influence the health and well-being of individual employees, and is expected to have a positive overall impact on both workplace productivity and engagement. Given that the provincial government is one of the largest employers in BC, the outcomes of this initiative are expected to be significant—leading by example.

Elder Abuse Prevention Strategy

The experience of abuse in its various forms (physical, psychological, emotional, financial, sexual and neglect) places older adults at risk for a variety of problems, including mental illnesses. At the July 2011 Council of the Federation meeting, the Premiers identified prevention of elder abuse as a priority for the provinces and territories. *Healthy Minds, Healthy People* includes an explicit commitment to implement a coordinated provincial initiative to prevent elder abuse so that seniors will be less vulnerable to abuse. This provides a mandate for a comprehensive and integrated approach to prevent elder abuse—both internal to government and jointly with external partners—that promotes healthy and active aging and age-friendly communities, builds efficiencies and leverages opportunities for action. The Ministry of Health is collaborating with Ministry of Public Safety and Solicitor General, the Ministry of Attorney General, and other partners across government to develop this strategy. Regional consultations commence in mid-February 2012.

Healthy Minds, Healthy People and BC's Innovation and Change Agenda

BC recognizes that promoting positive mental health and preventing mental illnesses where ever possible are key for health system and social sustainability, and as such *Healthy Minds, Healthy People* is well integrated throughout our innovation and change agenda.

BC's Innovation and Change Agenda

A key issue facing the British Columbia publicly funded health system, as in all OECD countries, is its ability to meet the increasing demands and needs of an aging population for quality health services while ensuring its sustainability into the future. Current projections show that unless we change how we meet the health care needs of citizens, spending pressure on the BC health system will increase at about six percent annually, with additional significant pressure for capital investment. This rate of growth is not sustainable - the health care system is incrementally taking more and more of global revenue at the expense of other government priorities and needs.

It is clear the status quo system will not sufficiently meet the growing demands of the aging population within a sustainable funding envelope. In 2010 the BC government developed a multi-year innovation and change agenda based on targeted and effective strategies to change the way services are delivered to best use the system's capacity to meet population demand. The Innovation and Change Agenda is based on four key themes that present practical ways to meet that demand through improved delivery of services. Specific actions within these four themes are detailed in Key Result Areas.

The Innovation and Change Agenda themes are as follows:

- 1. Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.**
 - Implement targeted health promotion and prevention initiatives to reduce the incidence of chronic disease.
 - Streamline core public health services to improve delivery
- 2. British Columbians have the majority of their health needs met by high quality primary and community based health care and support services.**
 - Implement an integrated model of primary and community care to more effectively meet the needs of frail seniors and patients with chronic and mental health and substance use conditions.
- 3. High-quality hospital services are available when needed.**
 - Use patient-focused funding to increase access to cost-effective elective surgeries and improve efficiencies in other hospital services.

- Improve the quality, safety and consistency of key clinical service by implementing a guideline-driven clinical care management system for hospital care.
- Drive LEAN across the hospital service sector - reduce waste and increase value (efficiency and effectiveness) of hospital services.
- Optimize the efficiency and effectiveness of the BC Ambulance Service.
- Achieve greater efficiency in the delivery of quality diagnostic services.

4. Improved innovation, productivity and efficiency in the delivery of health services.

- Optimize use of health human resources to improve clinical care and productivity.
- Improve patient safety and access to records through enhancements to the Health CareCard.
- Complete the implementation of eHealth.
- Reduce the cost of drugs, equipment and supplies.
- Drive savings through the consolidation of administrative services across the Lower Mainland.
- Redesign capital planning to optimize use of budget capacity.
- Optimize governance, leadership and operational and change management capacity.

Together these 15 key result areas provide an integrated and coherent strategy to improve both quality and the cost structure of the health system.

MEETING ADVICE FOR MINISTER

CLIFF #: 917054 xRef: 916625 & 910013

DATE OF REQUEST: January 26, 2012

REQUESTER: Mental Health Commission of Canada (MHCC)

MEETING REQUEST/ISSUE:

The MHCC has asked to meet with the Minister at the Manitoba Summit – “Mental Health Promotion and Mental health for all” on February 15-16, 2012

- To provide an update on the activities of the Commission
- To discuss the MHCC’s homelessness demonstration project “At Home/Chez Soi”.

BACKGROUND:

The Mental Health Commission of Canada’s (MHCC) mission is to promote mental health in Canada, and work with stakeholders to change the attitudes of Canadians toward mental health problems, and to improve services and support.

- The MHCC tabled its first draft of its Mental Health Strategy for Canada in July 2008. The draft was circulated nationally for review in January 2009.
- In November 2009, the MHCC further released their strategy document *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*.
- Work has subsequently been underway to develop a mental health strategy for Canada that will translate the vision and goals of the Commission’s Framework into a strategic plan. Eight strategic directions have been identified. The first five set out an agenda for transformation, while the remaining three focus on building capacity to enable transformation.
- Over the course of 2011, priorities for action have been determined for each of these strategic directions. The final step in developing a mental health strategy for Canada has been to identify priority actions under each strategic direction.
- The BC Ministry of Health are members of the MHCC Provincial/Territorial Mental Health Reference Group.
- BC Ministry of Health and Ministry of Children and Family Development staff have provided feedback to the MHCC draft documents to ensure alignment with BC’s *Healthy Minds, Healthy People: a Ten-year Plan to Address Mental Health and Substance Use in British Columbia*.

DISCUSSION:

A final draft was circulated for feedback in December 2012. BC has provided considerable feedback as follows.

- The strategy would benefit from adopting a life course lens or entrenching a developmental approach as a principle, acknowledging the impact of the life trajectory on mental health status. Beginning from the place of maternal health, to early childhood, to youth, to adult, to old age, etc.
- The strategy could also benefit from adopting other guiding principles such as a strengths-based approach, and a whole person approach—acknowledging the complex interplay between mental and physical health.
- Although there is significant emphasis within the strategy on social factors such as poverty and access to safe and stable housing as determinants of health with respect to severity of illness and opportunities to stabilize/recover, there is very little that addresses how such factors should be addressed.
- The engagement with indigenous populations in Canada in the development of this document, especially with those at a community and service provider level needs work.
- The strategy does not reflect on how the commission plans to link with Provincial and Territorial governments who have the responsibility and accountability for the planning and implementation of Mental Health and Substance use services within their jurisdictions.
- The MHCC has initiated projects that are at varying stages of implementation with little involvement of the provinces.
- The At Home/Chez Soi project has been piloted across Canada, including in BC. The MHCC is seeking the provinces to assume responsibility for the projects and to provide ongoing funding.

POLICY ISSUES:

- The *Premiers' Focus on Families* communiqué highlighted the importance of promoting positive mental health and preventing mental illnesses for all Canadians. s. 16
s. 16
- There are some alignments with BC's *Healthy Minds, Healthy People*, 10 year plan to address Mental Health and Substance Use, s. 16
s. 16
- The draft strategic plan discusses many operational or program and service approaches that may result in direct financial implications to the provinces.
- The design and delivery of programs and services is the responsibility of the FPT governments and their agencies.
- The MHCC must explicitly identify opportunities to partner with their FPT colleagues in the release and implementation of its strategic plan.
- The MHCC is seeking the provinces fund their programs, in particular the "At home Chez Soi" program. BC has advised the MHCC it has no new funding.

ADM RESPONSIBLE:

- Heather Davidson, Health Authorities Division
- Arlene Paton, Population and Public Health Division (Arlene is attending the Manitoba Summit)

RECOMMENDATION:

Recommend that the Minister meet with the MHCC. Such a meeting would be helpful in receiving an overview of the MHCC activities.

SHOULD MINISTRY STAFF ATTEND (AND IF SO, WHO)**Yes:**

- Arlene Paton, ADM
- Warren O'Briain, Executive Director
- Sandy Wiens, Executive Director, Ministry of Children and Family Development

DATE:**APPROVED BY:**

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 921317

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

TITLE: Lobbying by Vaccine Manufacturer Merck Concerning the
Human Papillomavirus Vaccine (Gardasil) and its Use with Males

PURPOSE: To provide context and information ahead of anticipated requests by Merck to
meet with elected officials regarding the Human Papillomavirus vaccine

BACKGROUND:

Currently there are two Human Papillomavirus vaccines (HPV) approved in Canada. Cervarix, by GlaxoSmithKline, is a bivalent HPV vaccine approved for use as protection against cervical cancer only, although preliminary data suggest that the vaccine also protects against anal, vaginal and vulvar cancer. Gardasil, by Merck, is a recombinant vaccine that is approved for use as protection against cervical cancer, as well as anal, vaginal and vulvar cancers, and genital warts. Both HPV vaccines are cost-effective, and both have excellent safety profiles.

British Columbia's routine HPV immunization program, which uses Gardasil, began in 2008 with an initial 3 year catch-up program for Grade 9 girls, and an ongoing program for girls in Grade 6. As of June 2011, all girls up to Grade 12 (aged 17-18) have been offered this vaccine.¹ On January 23, 2012, the Ministry of Health (MoH) approved a one-time only HPV vaccine program, using Cervarix, for women born in 1991, 1992, and 1993, to begin in mid-April of 2012.² (This offers coverage to women aged 19-21.)

Cervarix was chosen through a "Request for Proposals" (RFP) process and was selected because the cost of the vaccine was S. 17, S. 21 the number of young women to be vaccinated against HPV with associated protection against cervical cancer. Merck has stated S. 21

S. 21 (Note: The option to use Cervarix is supported by the HPV Vaccine Working Group. The membership list is attached as Appendix A.)

Although Health Canada had approved the use of Gardasil for males in February 2010, coincidentally, in January 2012, the National Advisory Committee on Immunization (NACI)—which makes recommendations regarding the use of vaccine in Canada—specifically recommended Gardasil for males 9-26 years of age in preventing anal and penile cancers, and genital warts.

¹ HPV immunization coverage rates are 68.2 percent in grade 6 and 61.7 percent in grade 9 as of June 2011 (BCCDC).

² See MoH BN #913572

DISCUSSION:

With Health Canada's approval and NACI's recent recommendation of the use of Merck's Gardasil vaccine in males, the prevention of IIPV for both sexes is possible. However, over the long term, a female-only HPV immunization program, like BC's, will lead to reductions in male cancer rates at a population level as IIPV disease prevalence is gradually reduced. While immunizing boys and young men will provide immediate protection for those immunized against anogenital and oral cancers, it is unclear how immunizing males would accelerate reductions in population prevalence of IIPV infections or in female IIPV-linked cancer rates, in a jurisdiction that already targets young women with its existing HPV immunization program.

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The BC Communicable Disease Policy Advisory Committee (the Committee) led by the Provincial Health Officer, makes vaccine recommendations to government, after vaccine approvals by Health Canada and recommendations from NACI have been given. The committee examines international, national and local evidence and considers overall benefit, before making its recommendations to government. Currently, the committee is considering a number of new vaccines; however, once the Canadian cost effectiveness studies regarding males and HPV immunization is complete, the committee will examine the findings and make recommendations to government for program options in BC.

In the meantime, males (9-26 years of age) or their parents have the immediate option to consult with their physician regarding privately purchasing the vaccine.

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Program ADM/Division:	Arlene Paton, ADM, Population and Health Division, 250-952-1731
Program Contact (for content):	Warren O'Briain, Executive Director Craig Thompson, Director, Immunization, 778-397-3360
Drafter:	Craig Thompson
Date:	22 March 2012
File Name with Path:	R:\CDAP\CDAP\AI Admin\Executive 280\20 BNs\20 Imm\Imm 2012\921317 - Merck HPV For Males.docx

Appendix A

HPV Vaccine Working Group Organization Membership

BC Centre for Disease Control

Ministry of Health

BC Cancer Agency Cervical Cancer Screening Program

BC Cancer Agency, Population Oncology

BC Cancer Agency Colposcopy Program

Vaccine Evaluation Centre and BC Children's Hospital

BC Women's Hospital

PHSA/LMC Laboratories and Cervical Cancer Screening Program

Regional Health Authorities

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 926112

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

TITLE: Tuberculosis operational planning in British Columbia

PURPOSE: To update the Minister of Health (the Minister) on recent provincial tuberculosis operational planning.

BACKGROUND:

With more than 8.8 million new cases and 1.5 million deaths worldwide in 2010, tuberculosis (TB) remains one of the world's deadliest diseases.¹ In BC, great strides in treatment and prevention have significantly reduced the impact of this disease; however, control is far from complete. In the years 2005-2008, the overall incidence rate in BC was 7.1 cases per 100,000 people, 58 percent higher than the overall Canadian rate of 4.5 cases per 100,000 people.² Rates among Aboriginal peoples living off-reserve in BC remain especially high (40.4 cases per 100,000). In 2011, regional health authorities through the BC Communicable Disease Policy Advisory Committee agreed to renew and solidify efforts to control this disease through the development of an operational plan to improve TB-related service delivery.

DISCUSSION:

The plan—attached for reference as Appendix A—aims to reduce TB in the province. It focuses on five goals that galvanize the activities of all health authorities, and contains operational objectives and a series of actions to reduce TB prevalence, morbidity and mortality. The plan is designed to optimize, and where needed, realign existing resources within BC's TB prevention and control program. The plan complements Health Canada's *Strategy against Tuberculosis for First Nations On-Reserve*, and the Public Health Agency of Canada's draft *Guidance for Tuberculosis Prevention and Control Programs in Canada*.

CONCLUSION:

TB rates in BC remain higher than the national average and are particularly high among Aboriginal British Columbians. To renew and solidify efforts to control this disease, an operational plan to improve TB-related service delivery has been developed. The plan optimizes existing resources in order to reduce TB prevalence, morbidity and mortality. The plan will be posted on the BC Centre for Disease Control website and letters from the Provincial Health Officer thanking stakeholders that helped with the plan's development will be sent. The interim First Nations Health Authority and First Nations Inuit Health branch were involved with the plan's development and are supportive of the renewed operational efforts articulated within it.

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¹ *WHO Report 2010: Global tuberculosis control*. WHO Global tuberculosis control: a short update to the 2009 report. WHO/HTM/TB/2010.7.

² BC Centre for Disease Control. *Tuberculosis Control Annual Report*. Accessed April 19, 2011: http://www.bccdc.ca/NR/rdonlyres/4E5E68CC-12CD-42A5-88DC-7CE57E31FEAF/0/2005_2008MultiAnnualTBReport_LowResAmended_Nov10.pdf.

BC Strategic Plan for Tuberculosis Prevention, Treatment and Control

BC Communicable Disease Policy Committee

March 30, 2012

In addition to the large number of groups and people listed in Appendix A, the following organizations have played a significant role in the development of the *BC Strategic Plan for Tuberculosis Prevention, Treatment and Control*. The multiple partners highlight the joint ownership of tuberculosis control from a wide cross-section of the health system.



BC Centre for Disease Control
An agency of the Provincial Health Services Authority



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Interior Health



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Promoting wellness. Ensuring care.



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Executive Summary

With more than 8.8 million incident cases and 1.5 million deaths worldwide in 2010, tuberculosis (TB) remains one of the world's deadliest diseases. Great strides in treatment and prevention have significantly reduced the impact of this disease in British Columbia (BC); however, control is far from complete. Over the past five years, approximately 300 people were diagnosed with TB annually, with an average incidence of 7.0 cases per 100,000 people. TB has also become increasingly concentrated among three populations over the past decades: foreign-born Canadians from tuberculosis-endemic countries, Aboriginal peoples, and socially marginalized individuals.

The *BC Strategic Plan for Tuberculosis Prevention, Treatment and Control* is a framework through which we can improve the health of people in BC by guiding and supporting efforts to reduce TB incidence, prevalence, morbidity and mortality. The plan was developed through 36 intensive discussion sessions with a broad range of stakeholders representing numerous health care, social service and advocacy organizations.

The vision of the plan is to greatly reduce TB incidence and transmission in BC. A roadmap for achieving this vision is contained in five strategic goals, which are supported by detailed objectives and strategies. These objectives and strategies are intended to guide decision-makers and service providers in their day-to-day operations.

Achieving the five strategic goals will take considerable effort across the health system and will require comprehensive strategies that engage the public, decision makers, and service providers to ensure TB prevention and treatment remain a priority. This demands the collaborative effort of many groups in BC, including health authorities, physicians, allied health care workers, and community organizations.

With the BC Ministry of Health providing executive stewardship, provincial public health services are provided by the Provincial Health Services Authority (PHSA), First Nations and Inuit Health Branch (which, at the time of this writing, is in the process of being transferred to the First Nations Health Authority) and the five regional health authorities (Vancouver Coastal Health, Fraser Health, Interior Health, Northern Health, and Vancouver Island Health).

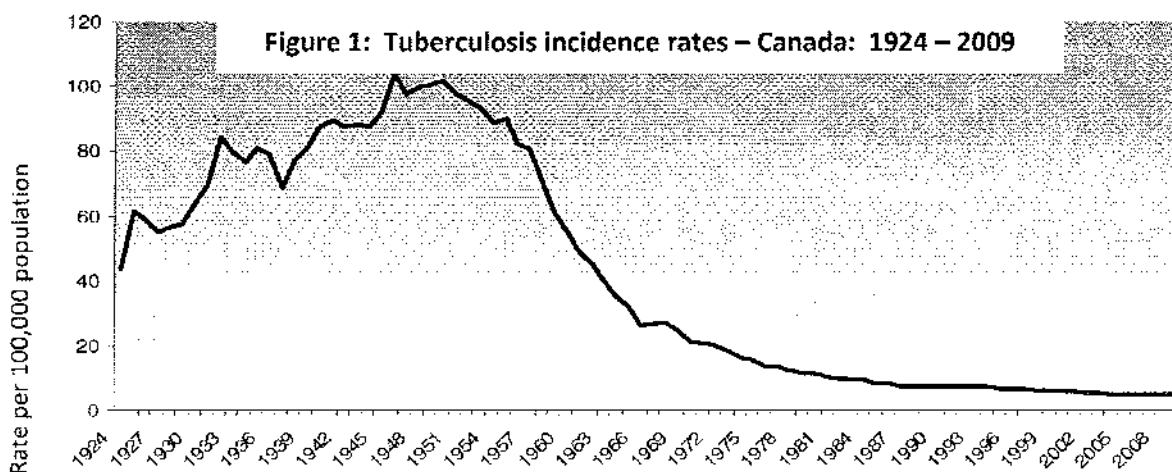
Milestones will assess progress at various stages over the course of the plan. To ensure implementation and accountability, a committee comprised of the major stakeholders will be responsible for reaching the milestones, with particular attention on the priority actions, and will provide annual progress reports and updates to the Communicable Disease Policy Advisory Committee.

Introduction

Tuberculosis (TB) is an infectious disease caused by *Mycobacterium tuberculosis*, a bacteria spread from person to person through air droplets. TB disease – also known as active TB – usually affects the lungs (pulmonary TB) but can also affect other organs, including the lymph nodes, brain, and spinal cord (extrapulmonary TB) amongst others. Left untreated, a person with infectious pulmonary TB can infect an average of 10 – 15 people every year.¹ When appropriately managed, however, active TB is largely curable and usually preventable.

At the turn of the twentieth century, TB was a leading cause of death and disability in British Columbia (BC). Fortunately, like many other high-income regions, BC has made tremendous progress in TB control over the past century, with the rates decreasing to among the lowest in the world (see Figure 1). Undoubtedly, improved socioeconomic conditions and antimicrobial therapy contributed to this decline, but credit also goes to the dedicated nurses, doctors and public health officials who built, adapted and sustained our robust provincial TB prevention and treatment program.

Despite great strides in treatment and prevention, TB control efforts in BC are far from complete. With more than 8.8 million incident cases and 1.5 million deaths worldwide in 2010, TB remains one of the world's deadliest diseases. Moreover, drug-resistant strains are proliferating globally, threatening to destabilize current control efforts. For this reason, TB constitutes a global health emergency, and remains a constant threat to provincial TB control.²



On a provincial level, considerable regional variation in approaches to TB control have developed over the past 40 years. As the legally responsible officials for TB control in BC, there has been keen interest among the Medical Health Officers to review the delivery of provincial TB prevention and treatment services and to explore opportunities to build on the successful practices currently in place.

¹ <http://www.who.int/mediacentre/factsheets/fs104/en/>

² WHO Report 2010: Global tuberculosis control. WHO Global tuberculosis control: a short update to the 2009 report. WHO/HTM/TB/2010.7.

The TB Strategic Plan will improve the health of people in BC by guiding and supporting health system efforts to reduce the incidence, prevalence, morbidity and mortality associated with TB. In the following pages, a shared vision serves as a blueprint for strategic leadership on reducing TB transmission in BC through five strategic goals:

1. Reduce incidence of active tuberculosis in British Columbia by 50 per cent by 2022.
2. Prevent transmission of tuberculosis within BC, in part by addressing social determinants of health such as housing, mental health and addictions treatment.
3. Prevent the development of active tuberculosis in those with latent tuberculosis infection, especially in new immigrants from high prevalence countries.
4. Ensure that the public health tuberculosis response is robust, timely and able to meet ongoing and outbreak needs.
5. Ensure state-of-the-art laboratory programs, treatment, and care of people who develop tuberculosis to improve outcomes and reduce the risk of spread.

Three milestones for achievement reflect the commitment to accountability and improving the health of British Columbia.

1. By 2022 British Columbia will reduce the incidence of active tuberculosis by 50 per cent.
2. By 2022 British Columbia will reduce the incidence of active tuberculosis in specific high risk and vulnerable groups by 50 per cent.
3. By 2017, all performance targets from the *Guidance for Tuberculosis Prevention and Control Programs in Canada* will be reached in:
 - Microbiological diagnosis of tuberculosis
 - HIV serologic testing
 - Treatment of tuberculosis
 - Contact follow-up
 - Targeted screening for active tuberculosis and latent tuberculosis infection
 - Immigration medical surveillance

Achieving the five strategic goals will take considerable effort across the health system and will require comprehensive strategies that engage the public, decision makers, and service providers to ensure TB prevention and treatment remain a priority. This demands the collaborative effort of many organizations responsible for health and social services in BC, including health authorities, physicians, allied health care workers, and community organizations.

TB Overview

International Context

The burden of TB is distributed unequally, with the vast majority of cases and deaths occurring in resource-poor regions. While the highest incidence rates of TB occur in African countries, the majority of cases occur in Asia; close to half of all new global cases occur in just six Asian countries: China, India, Philippines, Indonesia, Bangladesh and Pakistan.³

With adequate medical and public health resources, TB control programs can successfully treat most TB cases, while attenuating most community transmission. Indeed, the World Health Organization (WHO) recommended “short course” treatment protocol has been available for over 30 years and is one of the most cost-effective of all public health interventions.⁴ However, poverty and inadequate public health infrastructure have restricted access to TB diagnostics and treatment. According to the WHO, more than two million incident cases are undiagnosed and untreated each year.⁵ Fortunately, there have been recent gains in global TB control; global incidence has decreased by 1.3% per year since 2002, while the absolute number of incident cases has been falling since 2006.

Guided by the WHO Stop-TB Partnership, a Global Plan for TB control has been developed. The Global Plan calls for scaling up of interventions related to the treatment of active TB and latent TB infection (LTBI), encourages addressing multi-drug resistant TB (MDR-TB) and TB-HIV co-infection, and emphasizes the importance of advocacy, care provider engagement and fostering community participation in TB control efforts.⁶

In line with the United Nations Millennium Development Goals, the Global Plan has set a goal to reduce TB prevalence and the number of TB related deaths by 50 per cent in 2015 relative to 1990. The Global Plan also set the ambitious goal of eliminating TB by 2050, with elimination defined as less than one case per million people per year.⁷

National Context

Nationally, the Stop TB Canada initiative is an active part of the global movement to accelerate social and political action to stop the spread of TB. In 2006, the Canadian Tuberculosis Committee reviewed its national goal in the context of targets set by the WHO STOP-TB Partnership and recommended a target reduction of 50 per cent of TB rates by 2015 (3.6 cases per 100,000 people compared to the 1990 rate of 7.0 cases per 100,000 people).⁸ The Public Health Agency of Canada (PHAC), through the Division of

³ WHO Report 2010: Global tuberculosis control. WHO Global tuberculosis control: a short update to the 2009 report. WHO/HTM/TB/2010.7..

⁴ Murray CJ, DeJonghe E, Chum HJ, Nyangulu DS, Salomao A, Styblo K. Cost effectiveness of chemotherapy for pulmonary tuberculosis in three sub-Saharan African countries. *Lancet*. 1991 Nov 23;338(8778):1305-8.

⁵ WHO Report 2010: Global tuberculosis control. WHO Global tuberculosis control: a short update to the 2009 report. WHO/HTM/TB/2010.7.

⁶ Stop TB Partnership and World Health Organization. Global Plan to Stop TB 2006-2015. Geneva, World Health Organization, 2006 (WHO/HTM/STB/2006.35).

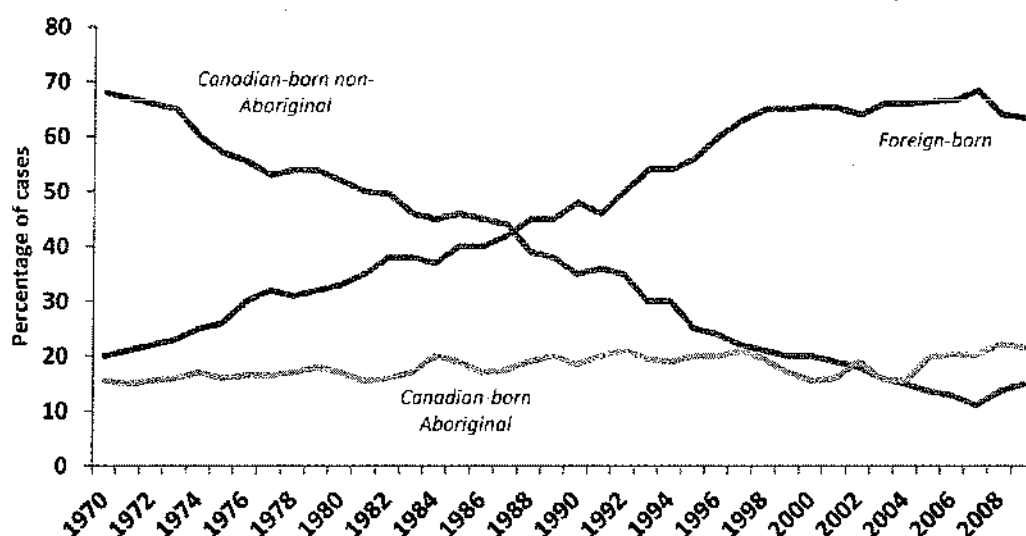
⁷ Stop TB Partnership and World Health Organization. Global Plan to Stop TB 2006-2015. Geneva, World Health Organization, 2006 (WHO/HTM/STB/2006.35).

⁸ Long R and Ellis E. Canadian Lung Association, Canadian Thoracic Society, Tuberculosis Prevention and Control. Canadian TB standards. 6th ed. Ottawa, Canada: Canadian Lung Association and Government of Canada, 2007.

Tuberculosis Prevention and Control, has endorsed this goal. At the time of this writing, PHAC and the First Nations and Inuit Health Branch of Health Canada (FNIHB) are in the process of renewing their National Tuberculosis Elimination Strategies.⁹

Presently, TB rates in Canada are amongst the lowest in the world. The overall incidence in Canada has decreased from 120 cases per 100,000 people in 1950 to less than five cases per 100,000 people in 2009.¹⁰ In addition, surveillance and treatment programs appear to be functioning well; all known TB cases are reported to provincial TB control programs, there are low levels of drug resistance, and there is universal access to free TB medications.

Figure 2: Proportion of tuberculosis cases by origin in Canada: 1970 - 2009



Provincial Context

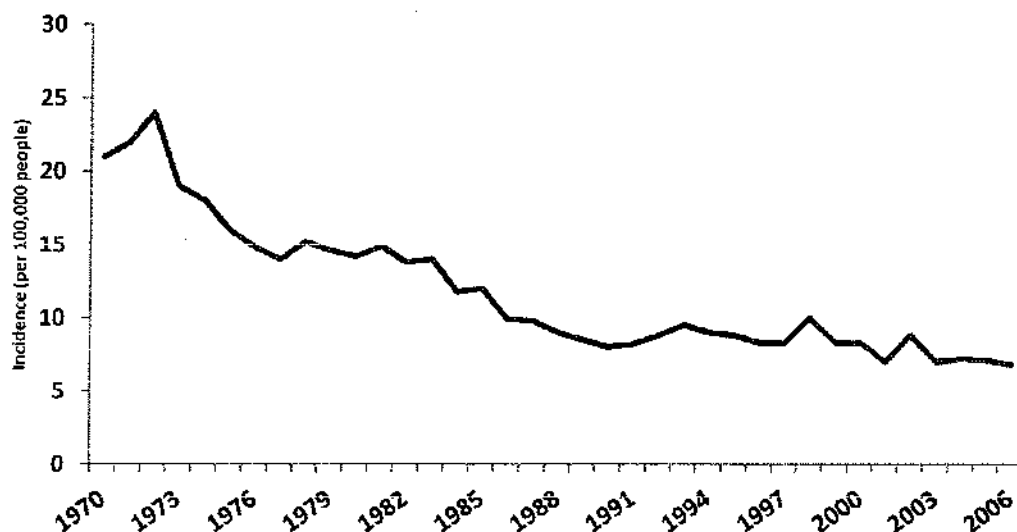
Over the last 50 years, TB rates in BC have decreased to very low levels. In the last 5 years, approximately 300 people were diagnosed annually with TB, with an average incidence rate of 7.0 cases per 100,000 people¹¹. Individuals with TB are diagnosed throughout the province, including remote communities, although more than 70 per cent of cases occur in the Greater Vancouver Region. In the 1980s, TB rates were falling by an average of over 5 per cent annually; however, in the last 5 years, these rates have decreased by less than 2 per cent per year (Figure 3). With the decline in overall incidence, TB has become increasingly concentrated among three populations in BC: foreign-born Canadians from TB-endemic countries, Aboriginal peoples, and socially marginalized individuals.

⁹ Health Canada. National TB Elimination Strategy. <http://www.hc-sc.gc.ca/fniiah-spnia/diseases-maladies/tuberculosis/intro-eng.php> accessed September 20, 2011.

¹⁰ Long R and Ellis E. Canadian Lung Association, Canadian Thoracic Society, Tuberculosis Prevention and Control, et al. Canadian tuberculosis standards. 6th ed. Ottawa, Canada: Canadian Lung Association and Government of Canada, 2007.

¹¹ BCCDC Provincial TB Elimination Strategy, BC Centre for Disease Control, an Agency of the Provincial Health Services Authority, July 2010, p.11.

Figure 3: Annual Incidence of TB in British Columbia ¹³



TB in people born in high incidence countries

Foreign-born persons account for an increasing proportion of national and provincial TB cases. This likely reflects several phenomena, including the decrease in TB incidence in Canadian born populations, the increase in proportion of foreign-born populations in Canada, and an increasing proportion of immigrants from high incidence countries (defined as a TB incidence rate exceeding 15 cases per 100,000). In 2009, foreign-born populations accounted for 63 per cent of all reported TB cases in Canada and 66 per cent of reported cases in BC.¹²

TB in Aboriginal Peoples

Despite increased efforts, the rate of TB in Aboriginal peoples remains consistently higher than the rate in foreign-born and Canadian-born non-Aboriginal people (Figure 4). The TB rate in Aboriginal peoples is six times higher than the national average, which is in part related to social, economic and environmental factors affecting Aboriginal communities.¹³ The rates of TB in Aboriginal peoples have been very slow to decline over the last 20 years. Indeed, in 2008, the rate of TB in BC Aboriginal peoples reached the highest level in over 5 years at 28.2 cases per 100,000 people.¹⁴

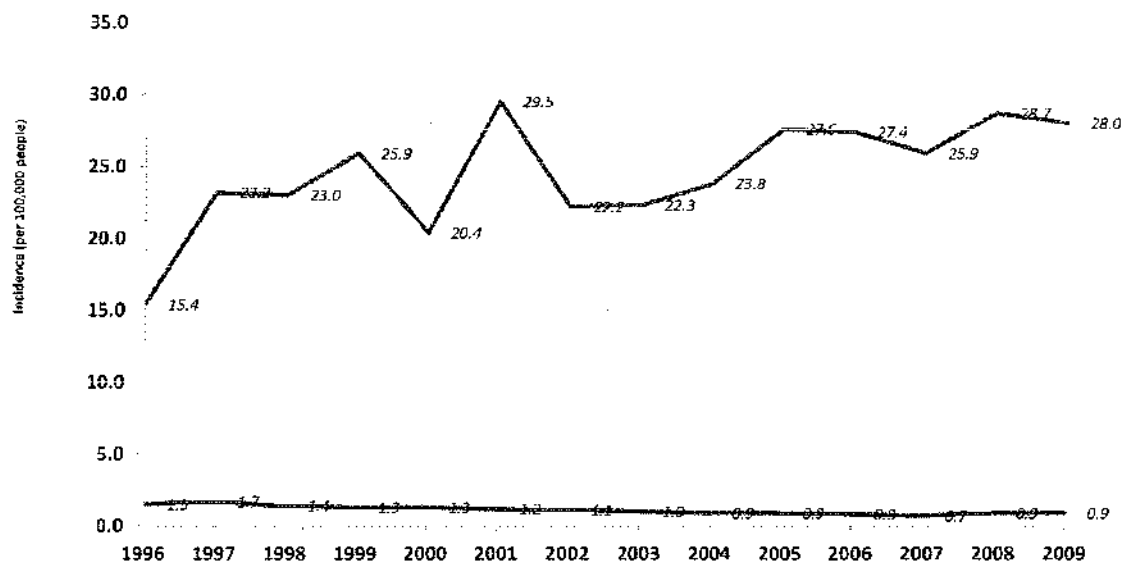
¹² Public Health Agency of Canada, Tuberculosis in Canada 2009 – Pre-release, <http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbcan09pre/index-eng.php#t3>, cited in BCCDC Provincial TB Elimination Strategy July 2011, p.10.

¹³ Public Health Agency of Canada, Tuberculosis in First Nations Communities, 1999. http://www.hc-sc.gc.ca/fniiah-spnia/pubs/diseases-maladies/tuberculosis/1999_commun/index-eng.php#a5. Accessed September 21, 2011..

¹⁴ Public Health Agency of Canada, Tuberculosis in Canada 2008 – Pre-release.

<http://www.publichealth.gc.ca/tuberculosis>, in BCCDC TB Elimination Strategy, July 2010, p. 10.

Figure 4: Annual incidence of TB in BC among Aboriginal and Non-Aboriginal Canadian-born People



Health Canada first implemented a national strategy to eliminate TB among Aboriginal peoples in 1992.¹⁵ The original goal of this strategy was to reduce TB incidence to less than one new case per 100,000 people by the year 2010.

TB in marginalized individuals and other groups at high risk

Those who are marginalized in society, for reasons that may include mental illness, problematic substance use, poverty, and homelessness, are at an increased risk of TB exposure and disease. Exacerbating risk in this population is the inability of health care services to engage and meet the needs of marginalized people.¹⁶ Other high risk groups include recent contacts of infectious TB cases, and those with immunosuppressive co-morbidities such as diabetes mellitus, chronic kidney disease, HIV infection, therapeutic immunosuppression and structural lung disease. High risk groups account for over 30 per cent of TB cases in BC annually, with HIV co-infection present in six percent of all active TB cases¹⁷. Table 1 describes the relative risk of developing TB for various cohorts.¹⁸

¹⁵ Medical Services Branch Working Group on Tuberculosis. National tuberculosis elimination strategy. Ottawa: Medical Services Branch; 1992.

¹⁶ Ivanova, Iglika (2011). The Cost of Poverty in BC. Vancouver: Canadian Centre for Policy Alternatives.

¹⁷ Estimate based on iPHIS review of TB cases in 2009.

¹⁸ Long R and Ellis E. Canadian Lung Association, Canadian Thoracic Society, Tuberculosis Prevention and Control, et al. Canadian tuberculosis standards. 6th ed. Ottawa, Canada: Canadian Lung Association and Government of Canada, 2007.

Table 1: Risk Factors for the Development of TB Disease among Persons Infected with *Mycobacterium tuberculosis*

Risk Factor	Estimated Risk of TB Relative to Persons with No Known Risk Factor
HIGH RISK	
Acquired immunodeficiency syndrome (AIDS)	110 – 170
Human immunodeficiency virus (HIV) infection	50 – 110
Transplantation (related to immunosuppressant therapy)	20 – 74
Silicosis	30
Chronic renal failure requiring hemodialysis	10 – 25
Carcinoma of head and neck	16
Recent TB infection (≤ 2 years)	15
Abnormal chest x-ray – fibronodular disease	6 – 19
INCREASED RISK	
Treatment with glucocorticoids	4.9
Tumor necrosis factor (TNF) – alpha inhibitors	1.5 – 4
Diabetes mellitus (all types)	2.0 – 3.6
Underweight (< 90 percent ideal body weight; for most persons this is a body mass index ≤ 20)	2 – 3
Young age when infected (0 – 4 years)	2.2 – 5.0
Cigarette smoker (1 pack/day)	2 – 3
Abnormal chest x-ray – granuloma	2
LOW RISK	
Infected person, no known risk factor, normal chest x-ray	1

TB Services in British Columbia

Roles and Responsibilities

With the BC Ministry of Health providing executive stewardship, provincial public health services are provided by the Provincial Health Services Authority (PHSA) and the five regional health authorities (Vancouver Coastal Health, Fraser Health, Interior Health, Northern Health, and Vancouver Island Health Authorities). The First Nations and Inuit Health Branch of Health Canada also funds TB-related services as well as on-reserve public health, home care, environmental health, and problematic substance use services.

Individuals and families

Individuals and families play an important role in helping to stop TB. Ongoing reductions in TB depend in part on individuals and families having the knowledge, skills and ability to manage their health. Ongoing effective, responsive TB policies and programs depend on individuals and families having opportunities to provide input into them.

Communities

While not directly involved in providing TB services, local governments, community agencies, and business and employer organizations can play an important role in helping the health care system manage TB. Actions can range from local governments developing policies around crowded conditions in congregate settings to community agencies conducting TB education and screening activities.

First Nations Health Authority

On October 13, 2011, the federal and provincial ministers of health, along with the BC First Nations Health Council and BC First Nations Health Society signed the British Columbia Tripartite Framework Agreement on First Nations Health Governance that will ensure BC First Nations have a major role in the planning and management of health services for First Nations through a new First Nations health governance structure. The new governance structure includes the First Nations Health Authority, Tripartite Committee, First Nations Health Directors Association, and First Nations Health Council. These groups will be responsible for the leadership, coordination, planning, management, funding and service delivery of health programs for BC First Nations.

Frontline Health Care Providers

Primary care providers

Primary care providers, such as family physicians and nurse practitioners, support British Columbians to stay healthy, recover from illness, live with disease and cope with end of life. In general, a high capacity to access and understand health data is an extremely important skill for primary care providers to possess. This allows for the translation of health information into practical treatment plans for their patients. With regards to TB, primary care providers perform screening, arrange for follow-up diagnostic tests to confirm an infection, and support ongoing care and treatment. They can assess the impact of TB therapeutic intervention from a holistic perspective (e.g., consider how TB treatment may affect co-morbid conditions), and help to coordinate specialist care when it must be sought elsewhere. Please refer to Table 2 for more information on TB treatment responsibilities.

Respiratory and Infectious Disease specialists

Respiratory and infectious disease specialists have extensive training in TB diagnosis and treatment. They order and interpret diagnostic tests, and can initiate and refine appropriate therapies to treat TB and LTBI. They address complicated diagnostic and treatment issues, such as drug resistance or medication interactions. They work in close collaboration with primary care providers and public health practitioners (e.g., public health nurses and medical health officers) to ensure the best care for the individual and the safety of the public.

Table 2: People Responsible for Various Types of TB Treatment

Treatment Function	Person or Group Responsible
Primary Care	Physicians (local or at TB Prevention and Control), Nurse Practitioners, Nurses (public health or community health nurses), Directly-observed Therapy (DOT) Workers
Secondary Care	Physicians (local or at TB Prevention and Control), Local Hospitals
Tertiary Care	Dedicated Ward at Vancouver General Hospital for TB patients managed by on-site respirologists.
Patient Follow-up	Physicians (local or at TB Prevention and Control), Nurse Practitioners, Nurses (public health or community health nurses), Directly-observed Therapy Workers
Enforcement for Non-Adherent Patients (if necessary)	Regional Health Authority Medical Health Officers

Regional Health Authorities/ Treatment and Care

Regional Health Authorities, Medical Health Officers and Public Health Nurses

BC's regional health authorities play a central role in TB program delivery. In collaboration with BCCDC-TB Prevention and Control (see below), regional health authorities are actively involved in surveillance, contact investigation, and supervision of treatment of both TB disease and LTBI within their health regions under the direction of MHO's. Historically, the involvement in TB management and contact investigation varies by regional health authority and individual circumstances. Currently, the BCCDC-TB Prevention and Control clinics in Vancouver and New Westminster support direct public health services for the Vancouver Coastal health authority and some parts of Fraser Health. The remainder of Fraser, Interior and Northern health authorities, as well as Vancouver Island (except for Victoria), are supported through outreach from BCCDC Field-Operations (see below). In addition, regional health authorities address patient and worker infection and prevention control.

Medical Health Officers

Medical health officers are physicians who have specialty training in Public Health and Preventative Medicine. They use population health knowledge and skills to play leading and collaborative roles in the maintenance and improvement of the health and well-being of their communities. They are responsible, in collaboration with the public health team, for monitoring, preventing and controlling communicable and chronic diseases, investigating disease outbreaks and hazards to health, and coordinating public health responses to health threats. Medical health officers carry out legislated requirements of a number of public health statutes which pertain to communicable disease prevention and control, environmental health, tobacco harm prevention, drinking water protection and community care facility licensing. They are responsible for the prevention and control of TB in their region by maintaining awareness among clinicians of tuberculosis trends in the community, carrying out public health follow-up of TB, responding to clusters and outbreaks of TB, and guiding front line public health practice and research.

Public Health Nurses and Community Health Nurses

Public health nurses promote and protect the health of populations in diverse settings, such as community health centres, schools, street clinics, youth centres and nursing outposts, to meet the health needs of the whole or specific populations. They work with many partners in communities to implement maternal and child health promotion programs; disease and injury prevention programs; school health programs; sexually transmitted infection prevention programs that include treatment, education and outreach; immunization clinics; and communicable disease surveillance and control. They will often work closely with primary care providers, specialists, medical health officers and other regional health authority staff to ensure a coordinated response to TB case reports and outbreaks. Community Health Nurses provide the same functions as Public Health Nurses, with added responsibility for more general community development.

Provincial Health Services Authority (PHSA)

The PHSA is responsible for managing provincial agencies including the British Columbia Centre for Disease Control (BCCDC), the BC Cancer Agency, and other organizations that provide province-wide specialized health care services.

Provincial Public Health Microbiology & Reference Laboratory (PHMRL)

The Provincial Public Health Microbiology & Reference Laboratory (PHMRL) is the primary public health and reference diagnostic testing facility for British Columbia. The laboratory is also nationally recognized for its public health leadership, regularly conducting nationally funded scientific evaluation, and playing a leadership role in many areas including drinking water, molecular microbiology, influenza and health care acquired infections. It works closely with acute care laboratories in its BC Public Health Laboratory Network and its national counterparts across Canada in the Canadian Public Health Laboratory Network.

BC Centre for Disease Control (BCCDC)

The BC Centre for Disease Control (BCCDC), an agency of the PHSA, provides health systems leadership and supports regional health authorities to monitor, prevent and control communicable disease and promote environmental health in BC. It provides surveillance and response, applied scientific evaluation,

disease prevention and control, and infrastructure and training. The BCCDC is responsible for TB prevention and management through TB Prevention and Control (BCCDC-TBC) as described below.

TB Prevention and Control (BCCDC-TBC)

Organized in 1935 to provide TB services to people of BC, TB Prevention and Control (BCCDC-TBC) underwent a shift in mandate in 1944 from a sanatorium-based care model to providing services primarily in an outpatient setting (prior to 1944, there were no medications available to treat TB). BCCDC-TBC now lies within the Clinical Preventative Services Division of the BCCDC, and is the provincial centre of excellence for TB. BCCDC-TBC provides central coordination for TB surveillance, control and prevention efforts including family-centred care at its TB Control Clinics.

BCCDC-TBC works with regional health authorities to establish and maintain policies, standards and procedures for the control of TB in BC. This includes the provision of free medications for treatment of active disease and latent infection, administration of the centralized provincial TB registry database, Integrated Public Health Information System (iPHIS), and reporting of cases nationally.

BCCDC-TBC provides staffing for two clinics: Vancouver TB clinic in Vancouver Coastal Health Region and New Westminster TB clinic in Fraser Health Region.

BCCDC-TBC Field-Operations

The nurse led field-operations program works in collaboration with BCCDC-TBC physicians. The program provides remote technical support, clinical consultation and co-ordination of contact investigations throughout the province. Direct patient care is provided by local physicians. Active cases are typically assigned to a regional public health nurse who works with the physicians, BCCDC and the client to facilitate care. Depending on the available resources of the local public health unit, patients may receive outreach DOT support.

TB Services for Aboriginal Communities (TBSAC)

The TB Services for Aboriginal Communities (TBSAC) program at the BCCDC-TBC, funded by the BC Region of the First Nations and Inuit Health Branch of Health Canada, provides consultative services to physicians and nurses providing health care to First Nations individuals living on reserve. Services include technical support, physician & nursing clinical consultation, planning, coordinating screening efforts, education, surveillance, and scientific evaluation.

BC Ministry of Health and other Provincial Ministries

As stewards of the provincial health system, the Ministry of Health provides leadership and support to health system partners, including health authorities, physicians, and other care providers. The Ministry sets the overall strategic direction for the health system, provides the appropriate legislative and regulatory frameworks to allow it to function smoothly, and plans for the future supply and use of health professionals, technology, and facilities. The Ministry, particularly through the Office of the Provincial Health Officer, also monitors and reports on the health of the population and plans for and coordinates responses to major public health risks and emergencies.

The Ministry works to ensure a consistent level of service quality across the regions with no significant service gaps. It also evaluates health system performance, and takes corrective action where necessary to ensure the population's health needs are being met.

In addition to the Ministry of Health, other provincial ministries have an important role to play in the prevention and treatment of TB. For example, the Ministry of Public Safety and Solicitor General, through BC Corrections, is responsible for managing TB in provincial correctional institutions. Broader efforts across government and society address the systemic issues of poverty, literacy, and food security that effect where people live, work, and play.

Federal Government

At the national level, the Public Health Agency of Canada (PHAC) works with the provinces and territories to promote and protect the health of Canadians. A significant part of its mandate is to decrease the transmission of infectious diseases and to improve the health status of those infected.

PHAC is responsible for the overall management of tuberculosis Prevention and Control in Canada. This national prevention and control programme includes central coordination, monitoring and evaluation, with each province and territory being responsible for developing and implementing control plans that are consistent with Canadian guidelines and protocols.

Through the Centre for Infectious Disease Prevention and Control, surveillance and epidemiology, risk management, scientific evaluation including laboratory science, health promotion, public health policy development and prevention and care programs are delivered.

Citizenship and Immigration Canada (CIC) is responsible for assessing the health status of refugees and immigrants prior to their arrival in Canada. The Post-Landing Immigration Surveillance (PLIS) program is federally mandated to require people with evidence of LTBI on a chest x-ray to present to public regional health authorities for evaluation following arrival in Canada.

Correctional Services Canada (CSC), pursuant to the *Corrections and Conditional Release Act* (Section 86, Inmate Health), must provide every inmate with essential health care that conforms to professionally accepted standards. In 1997, in collaboration with Health Canada's Division of Tuberculosis Prevention and Control and Occupational Health and Safety Agency (now Workplace Health and Public Safety Programme), CSC developed an infrastructure for surveillance of TB in Canadian federal correctional institutions.

Figure 5 Key Roles and Responsibilities

Primary Care Providers

Clinical suspicion of TB or LTBI warranting treatment

Reporting TB cases and relevant clinical information to medical health officer

Primarily responsible for treatment, or referral to specialist (e.g. TB Control) for treatment

Monitor response to treatment; adjust as necessary in consultation with specialist

Liaise with public health service regarding treatment compliance

Recommend screening for latent tuberculosis

Regional Health Authority Medical Health Officers and Public Health Staff

Responsible for surveillance, prevention and control of TB in their region

Maintain index of suspicion and awareness of tuberculosis as a differential diagnosis in area physicians

Determine and carry out appropriate course of public health actions and follow-up around each case, including contact tracing (TBC often provides support in outbreak situations)

Report cases to the provincial TB Control program (acting on behalf of the Provincial Health Officer)

Primary management of clusters and outbreaks

Advise on and participate in development of locally relevant scientific evaluation

Provide TB education to staff involved in TB prevention and control services

Take lead role with media on local RHA TB issues

First Nations Health Authority

Responsible for program delivery, management and funding for First Nations communities in BC

BCCDC-TBC and PHMRL

Coordinate and lead provincial LTBI testing

Ensure the diagnostic capacity in the province sufficiently meets demand

Provide individual clinical consultation and medication management with local primary attending physician of each TB case

Consult with MHO or assigned RHA public health staff on local course of public health actions around infectious TB cases

Support RHA management of local TB cases, clusters and outbreaks

Coordinate development of and maintain provincial TB guidelines

Maintenance of provincial TB registry on behalf of the Provincial Health Officer

Conduct ongoing provincial TB surveillance, epidemiologic analysis and scientific evaluation e.g., provide quarterly reporting of cases to each health authority and produce an annual report on TB for BC

Share relevant and up-to-date information on the BCCDC website

Provide public awareness and education on TB prevention and treatment to assist with early diagnosis, early treatment and stigma reduction

Provide appropriate reporting of BC data to the Public Health Agency of Canada and other stakeholders

Liaise with PHAC and CIC Canada regarding policies, international air travel cases, and migrants

Take media lead on multi-regional or provincial TB issues, including bus conveyances

Dedicated nurse coordinates contact tracing activities for Vancouver, Richmond, and the North Shore. Contact tracing for FHA is handled out of the New Westminster clinic. This position also is responsible for lower mainland hospitals and all airline contacts

TB Services Review

The TB Strategic Plan was developed through 34 intensive discussion sessions with a broad range of individuals and organizations. Discussion sessions were conducted with the five regional health authorities, the Provincial Public Health Microbiology and Reference Laboratory, BC Centre for Disease Control, immigrant serving organizations, agencies that support persons with HIV/AIDS, Aboriginal, First Nations and Métis organizations, health care professionals, organizations that support workplace health and safety, federal and provincial correctional services, and a patient advocacy organization.

This Strategic Plan reflects the input from the discussion sessions as well as a review of the BC Centre for Disease Control Provincial TB Elimination Strategy, the FNIHB TB Program Performance Indicators and Targets (draft), and the United Nations Millennium Development Goals regarding TB. Major themes derived from this input are presented in the strengths, weaknesses, opportunities and challenges analysis below (Table 3).

As discussions across the province were carried out to inform this plan, a number of recurring and longstanding issues became apparent. Such issues included inconsistent responses to TB outbreaks; screening programs that differed from jurisdiction to jurisdiction; patient follow-up and contact investigation procedures that differed with procedures in other areas, even within the same health authority; uncertainty of roles for service provision to First Nations communities; and uncertainty of responsibility for clinical and public health service provision between TB Control and the regional health authorities. Overall, these issues reflect the effects of a series of major health system reorganizations on the tuberculosis program. These and other issues will be addressed through the goals, objectives, and actions of this strategic plan.

A list of organizations that participated in the TB Discussion Sessions is provided in Appendix A.

Table 3: Analysis of Tuberculosis Service Delivery in British Columbia

Strengths	Weaknesses
1. Centralized expert TB services that provide provincial surveillance, medication management, patient and provider education, reference laboratory, and field consultative support. 2. Well-established partnerships with other public health laboratory services and FNIHB. 3. Robust public health legislative framework. 4. Connected and coordinated communicable disease expertise through the regional health authorities. 5. Non-government partners who are willing to support and assist with provision of TB services.	1. Regional differences in public health response across BC create variation in prevention, testing, and care, which can contribute to inconsistency in outbreak response and general service provision. 2. Lack of coordinated effort for high quality TB surveillance. 3. Delayed reporting of centralized surveillance data to regional health authorities. 4. Uncertainty about allocation of screening resources, including possible misallocation to low-risk groups. 5. Inconsistent engagement of new Canadians from high-prevalence countries for LTBI therapy
Opportunities	Challenges
1. Increase spread and depth of education and TB literacy activities (e.g. through social marketing). 2. Develop consistent approach to outbreak management. 3. Redirect screening resources towards people at high risk of TB. 4. Apply new laboratory technologies such as IGRA, genomics, and PCR-based drug resistance testing. 5. Articulate and align roles and responsibilities of BCCDC and each RHA, and within RHAs. 6. Improve engagement with First Nations in the context of the Tripartite Agreement. 7. Linkages with other governmental and non-governmental social service agencies to address health inequities. 8. Improve linkages with Citizenship and Immigration Canada to strengthen surveillance, extend reach, and enhance engagement of new Canadians. 9. Improve linkages with correctional health services to improve continuity of care for admitted and released inmates. 10. Enhance surveillance and reporting activities. 11. Develop consistent infection control and occupational health process in health care settings. 12. Develop a coordinated and collaborative scientific evaluation and evaluation plan. 13. Engage new partners in TB service delivery (e.g. Directly Observed Therapy, health promotion, advocacy). 14. Integrate TB services into relevant chronic disease services.	1. Rising prevalence of people with chronic disease that predispose to TB reactivation (e.g. diabetes, cancer, renal disease, HIV). 2. Endemic spread of drug resistant TB (MDRTB) elsewhere in the world. 3. Increasing immigration from countries with high rates of TB and drug resistant TB. 4. Financial constraints.

Strategic Plan

A roadmap for reducing the incidence and impact of TB in BC is contained in five strategic goals, which are supported by detailed objectives and strategies. Their implementation is, in turn, guided by seven principles and values that are the foundation on which this Strategic Plan is built, and are intended to guide decision-makers and service providers in their day-to-day operations.

Principles and Values

Collaboration

TB service providers must collaborate in order to ensure seamless, low-barrier service delivery. Collaboration supports information sharing, communication and relationship building. Collaboration with and among community partners is essential to meet the needs of people with specific vulnerabilities. All TB service providers must have a clear understanding of their roles and responsibilities in achieving TB service delivery goals.

Patient-centered holistic care

TB service delivery must be patient-centred through ensuring multiple points of access, removing barriers and delivering services in a culturally competent manner. Patients can also assist in generating knowledge with respect to TB, and promoting awareness by teaching the general public. All partners will continue to not only improve access, but meaningfully engage patients into a health care system that supports and promotes a holistic vision of health.

Embracing innovation

To expand the reach of its programs and optimize TB service delivery, BC must be creative and innovative. This can occur through the use of new technology or implementing new strategies for reaching people with specific vulnerabilities.

Best evidence

Both the general public and health care professionals must be confident that the management of TB is based on the best available data and subjected to rigorous standards of analysis. A strong TB delivery services system must be supported by policies and procedures based in evidence and best practices.

Building capacity

Building capacity means developing, fostering, and supporting both the resources and the relationships required for TB service delivery at individual, organizational, inter-organizational, and systems levels. It also includes reporting on the collaborative processes developed, and sharing lessons learned.

Accountability, efficiency, and cost-effectiveness

TB services must be delivered efficiently and make the best use of limited resources by seeking all opportunities to achieve the best value. Services should also support community action initiatives.

Ethical, fair, and equal access and engagement

Directly addressing poverty, access and health care engagement, overcrowding and inadequate housing combined with supporting health literacy and an improved system of care for TB will result in further reductions in the TB burden.

Healthy public policy

Advocating for the health of patients and developing policy to increase health literacy among the general public as well as health care professionals will create a supportive environment where optimal TB-related outcomes can be achieved.

Plan at a Glance—Vision, Mission and Goals

VISION

Tuberculosis incidence and transmission in BC will be greatly reduced.

MISSION

Improve health in British Columbia by continuing to reduce the incidence of tuberculosis and its effects on individuals, families and communities through collaboratively delivered TB services, based on the best evidence and in a culturally competent manner.

Goal 1

Reduce incidence of active tuberculosis in BC by 50 per cent by 2022.

Goal 2

Prevent transmission of tuberculosis within BC, in part by addressing social determinants of health such as housing, mental health and addictions treatment.

Goal 3

Prevent the development of active tuberculosis in those with latent infection, especially in new immigrants from high prevalence countries.

Goal 4

Ensure that the public health tuberculosis response is robust, timely and able to meet ongoing and outbreak needs.

Goal 5

Ensure state-of-the-art laboratory programs, treatment, and care of people who develop tuberculosis to improve outcomes and reduce the risk of spread.

Priority Actions

The following priority actions link to the plan's goals and objectives (pages 25 – 31) and outline the areas where immediate attention is needed. They reflect two important aspects of moving forward: responding to immediate, pressing needs, and taking steps that will lay a solid foundation for future activities. They are not intended to be ranked, rather they are to be acted upon concurrently; action on some are already underway, with the remainder to be initiated by February 2013.

Articulate and align roles and responsibilities

- Work with the Primary Care and Public Health Tripartite Strategy Council to ensure collaborative service planning for First Nations in the context of the Framework Agreement and the Tripartite First Nations Health Plan. *(Goal 2, Objective 1.3)*
- As a tool to achieve many of the action and goals within the plan, each regional health authority and the BCCDC will develop service level agreements that define service level and resource allocation expectations of each party, including lab efficiencies. *(Goal 4, Objective 4.1)*

Enhance surveillance capacity

- Formalize a TB surveillance network that enables assessment of performance targets. *(Goal 4, Objective 1.1)*
- Formalize a process that communicates TB data between the BCCDC, Provincial Health Labs and regional health authorities in a timely manner. *(Goal 4, Objective 1.1)*
- Establish a TB surveillance lead in each regional health authority. *(Goal 4, Objective 1.3)*
- Establish tripartite protocols regarding Aboriginal TB surveillance data management. *(Goal 4, Objective 1.4)*

Improve monitoring and evaluation

- Develop monitoring and scientific evaluation priorities and review them biannually. *(Goal 4, Objective 5.1)*
- Develop a mechanism for sharing monitoring and evaluation results with stakeholders. *(Goal 4, Objective 5.3)*

Improve occupational health screening

- Reassess the occupational health and safety screening policy to identify workers or volunteers that warrant screening. *(Goal 2, Objective 2.1)*
- Improve the recording and monitoring of occupational safety screening results. *(Goal 2, Objective 2.3)*

Increase engagement, screening and treatment in high risk populations

- Utilize the BC Centre for Disease Control TB Manual, Canadian TB Standards and ATS Guidelines as resources to implement comprehensive screening for TB and LTBI. *(Goal 2, Objective 2.6)*
- Improve TB screening and identify and implement strategies to improve LTBI therapy adherence in high risk populations through active scientific evaluation, engagement and input from community stakeholders. *(Goal 3, Objective 1.3)*

Improve laboratory capacity

- Develop the BC Public Health Lab Network to empower work with regional health authority microbiology labs on better testing (for both TB and LTBI cases). *(Goal 5, Objective 2.1)*
- Support improvements needed to provide an appropriate level of enhanced molecular testing. *(Goal 5, Objective 2.2)*

Improve health literacy activities

- Broaden provincial awareness of TB and reduce associated stigma through community strategies including the promotion of regular events such as World TB Day (March 24th), Aboriginal-specific events and annual health/services fairs for new immigrants put on by MOSAIC and SUCCESS. *(Goal 4, Objective 3.2)*
- Identify existing TB educational programs for health care practitioners that may be adapted for use in BC. *(Goal 4, Objective 3.4)*

Improve contact tracing and outbreak investigation

- Develop a protocol to identify clusters versus outbreaks; manage and evaluate response to TB outbreaks and ensure a timely and seamless approach to TB outbreak management. *(Goal 4, Objective 2.1)*
- Increase the use of the standardized contact tracing approach outlined in the BCCDC TB Control Manual. *(Goal 4, Objective 2.2)*

Improve the management of active tuberculosis

- Develop guidelines for responding to people at high risk for non-adherence. *(Goal 5, Objective 3.1)*
- Expand DOT (directly observed therapy) TB treatment programs
 - Incorporate DOT TB treatment into other drug treatment platforms, e.g. for HCV, HIV, STIs, and the provision of methadone. *(Goal 5, Objective 3.2)*
- Explore the feasibility of including TB in provincial Chronic Disease Management Initiative. *(Goal 5, Objective 3.4)*
- Allocate resources to improve management of TB in high risk populations *(Goal 5, Objective 3.6)*
- Ensure that hospitals, correctional facilities, and public health work together to put community follow-up plans in place prior to individuals being discharged or released. *(Goal 5, Objective 4.1)*

Milestones

Milestones will help to mark progress at various stages over the course of the next 10 years. These milestones will serve as indicators of success and will be a component of the accountability framework to ensure that the objectives and actions set out below are achieving the goals set out in the plan.

1. By 2022 British Columbia will reduce the incidence of active tuberculosis by 50 per cent.¹⁹

- From 2005 - 2008, the overall incidence rate of TB in the province was 7.1 per 100,000 people.²⁰

2. By 2022 British Columbia will reduce the incidence of active tuberculosis in specific high risk and vulnerable groups by 50 per cent:

- Foreign born people from TB-endemic countries
- People with HIV infection
- Aboriginal peoples
- Homeless and under-housed populations

From 2005 - 2008, the incidence rate of TB in Aboriginal peoples was 32.2 per 100,000 people; the rate in foreign-born individuals was 19.2 per 100,000 people; the estimated rate of TB in HIV positive populations is 138 per 100,000 people.

The achievement of this milestone will limit secondary spread from these groups and consequently decrease the overall incidence of TB in British Columbia.

3. By 2017, all performance targets from the Canadian TB Strategy will be reached in:

- Microbiological diagnosis of TB
- HIV serologic testing
- Treatment of TB
- Contact follow-up
- Targeted screening for active tuberculosis and latent tuberculosis infection
- Immigration medical surveillance

¹⁹ In 2006 the Canadian TB Committee reviewed the national goal in the context of targets set by the STOP TB Partnership and recommended targeting a reduction in TB incidence 50 per cent by 2015 compared to 1990 levels (targeting 3.6/100,000 by 2015). The Public Health Agency of Canada has endorsed these goals. This was a 9-year goal. The BC Strategic Plan allows 10 years to reach this goal.

²⁰ BC Centre for Disease Control. Tuberculosis Control Annual Report. Accessed November 21, 2011: http://www.bccdc.ca/NR/rdonlyres/4E5E68CC-12CD-42A5-88DC-7CE57E31FEAE/0/2005_2008MultiAnnualTBReport_LowResAmended_Nov10.pdf.

Implementation and Evaluation

Successful implementation and measurement requires establishing targets, benchmarks, and standards associated with system-wide progress and success. A mechanism to ensure accountability for everything described in this strategic plan, especially the specific actions, will be established to guarantee meaningful action is taken. This mechanism will take the form of a committee comprised of the major stakeholders that will be responsible for reaching the milestones, with particular attention on the priority actions.

The committee will provide annual progress reports and updates to the Communicable Disease Policy Advisory Committee, construct a work plan, and develop an evaluation protocol among key partners, designed to complement existing monitoring activities and answer key questions. For instance, over time, are more at-risk people engaged in seeking and receiving treatment for TB? Has TB literacy improved? Has the capacity of the service delivery system been improved?

This plan has been developed to serve as a guide. Formal public progress reporting will be completed each year, beginning in 2013. Information gathered through program evaluation and surveillance will be provided as part of a continuous feedback loop to assist policy makers, managers, and service providers to make sound program decisions, and ensure public accountability. Information will also be distributed more broadly to encourage changes in attitudes and behaviours at the individual, family, and community level.

Over the long-term, progress reports will track advancement on attaining the plan's outcomes by answering the following questions:

- Have the plan's goals and milestones been attained?
- Are there improvements in program and policy to reach these milestones?
- Specifically, are there improvements in program and policies that address high risk populations?
- Are we on track to greatly reduce the transmission of TB in BC?

Goals, Objectives and Actions

Strategic Goal 1 - Reduce incidence of tuberculosis in BC by 50 per cent by 2022.

Strategic Goal 2 - Prevent transmission of tuberculosis within BC, in part by addressing social determinants of health such as housing, and mental health and addictions treatment.

OBJECTIVES and ACTIONS:

1. Reduce the transmission of tuberculosis by addressing determinants of disease spread.

- 1.1 Improve collaboration between the health system and social service agencies concerned with the social determinants of TB and promotion of patient wellness (e.g. shelter, housing and food security) by creating a mechanism to ensure ongoing and regular communication and information sharing between regional health authorities, TB Control, Ministry of Health, and relevant non-governmental agencies. *(Lead agency: BCCDC)*
- 1.2 Ensure that the systemic issues that affect where people live, work, and play are addressed in government plans on chronic diseases. *(Lead agency: Ministry of Health)*
- 1.3 Work with the Primary Care and Public Health Tripartite Strategy Council to ensure collaborative service planning for First Nations in the context of the Framework Agreement and the Tripartite First Nations Health Plan. *(Lead agency: Ministry of Health)*
- 1.4 Improve engagement of vulnerable people at risk for TB, and the organizations that support them, by establishing collaborative relationships that include promoting patient wellness, linking people to appropriate care, and ensuring follow-up. *(Lead agencies: Regional Health Authorities)*
- 1.5 Scientifically evaluate the role of social determinants in spreading disease, and identify areas of intervention to prevent TB transmission. *(Lead agency: BCCDC)*

2. Prevent transmission of tuberculosis in the workplace.

- 2.1 Reassess the occupational health and safety screening policy to identify workers or volunteers that warrant screening. *(Lead agency: BCCDC)*
- 2.2 Make recommendations to amend the Occupational Health and Safety Act regulations if needed. *(Lead agencies: Office of the Provincial Health Officer and the Ministry of Health)*
- 2.3 Improve the recording and monitoring of occupational safety screening results

- establish a clear process for communication between Infection Control, Occupational Health and Safety, and Public Health (example: reciprocal database access) (*Lead agencies: Regional Health Authorities*)
- 2.4 Improved understanding by employees to adhere to infection control precautions when a person with infectious TB is on a ward. (*Lead agencies: Regional Health Authorities*)
3. Employ screening programs using suitable methods (e.g., x-ray, sputum screening, symptom screening) at appropriate locations to enable early identification of TB cases among high risk groups.
- 3.1 Utilize the BC Centre for Disease Control TB Manual, Canadian TB Standards and ATS Guidelines as resources to implement comprehensive screening for TB and LTBI.
4. Reduce the transmission of tuberculosis in healthcare settings.
- 4.1 Create appropriate algorithms to triage, manage, and reduce TB transmission in health care settings. (*Lead agencies: Regional Health Authorities*)
- 4.2 Engage with the local infection control and clinical experts regarding the enhancement of infection control measures. (*Lead agency: BCCDC*)

Strategic Goal 3 - Prevent the development of active tuberculosis in those with latent infection, especially in new immigrants from high prevalence countries.

OBJECTIVES and ACTIONS:

1. Improve tuberculosis screening and treatment of populations who are at highest risk.
- 1.1 With input from community stakeholders, review and update the current TB screening policy and determine circumstances in which to introduce targeted screening for those at high risk or with specific vulnerabilities, e.g.
- persons with renal failure on dialysis
 - persons receiving anti-TNF therapy
 - persons receiving organ transplant
 - persons with diabetes mellitus
 - immigrants from high-incidence countries
 - marginalized hard-to-reach people, e.g. people who are homeless or who use psychoactive substances
 - people with HIV infection
 - Aboriginal peoples
- (*Lead agency: BCCDC*)
- 1.2 Identify the most effective venues for TB service delivery by population groups. (*Lead agencies: Regional Health Authorities*)

- 1.3 Identify and implement strategies to improve LTBI therapy adherence in high risk populations through active scientific evaluation, engagement and input from community stakeholders.

2. Improve follow-up of immigrants post-landing.

- 2.1 Improve linkages with Citizenship and Immigration Canada to strengthen surveillance, extend reach, and enhance engagement of new Canadians. *(Lead agency: Ministry of Health)*

3. Improve the identification and screening of contacts of infectious cases.

- 3.1 Increase the use of the standardized approach to contact investigations outlined in the BC Centre for Disease Control TB Manual. *(Lead agencies: Regional Health Authorities)*
- 3.2 Develop a standardized data collection protocol for contact investigation of TB. *(Lead agencies: Regional Health Authorities and BCCDC)*

Strategic Goal 4 - Ensure that the public health tuberculosis response is robust, timely and able to meet ongoing and outbreak needs.

OBJECTIVES and ACTIONS:

1. Improve tuberculosis surveillance.

- 1.1 Formalize a TB surveillance network. Issues to be addressed will include, but are not limited to:
 - assessing performance targets
 - describing TB and LTBI characteristics in each regional health authority
 - clarifying what data is acquired and analyzed
 - formalizing communication of TB data between the BCCDC, Provincial Health Labs and regional health authorities in a timely manner*(Lead agency: BCCDC)*
- 1.2 Develop provincial epidemiology capacity at BCCDC for TB. *(Lead agency: BCCDC)*
- 1.3 Establish a TB surveillance lead in each regional health authority. *(Lead agencies: Regional Health Authorities)*
- 1.4 Establish tripartite protocols regarding Aboriginal TB surveillance data management. *(Lead agencies: Ministry of Health, FNIHB, and BCCDC)*
- 1.5 Improve access for health care providers to data about people at risk for TB, including: people with HIV/AIDS, individuals on dialysis, transplant recipients, people with cancer, and people prescribed immunosuppressives. *(Lead agency: BCCDC)*

2. Improve outbreak management.

- 2.1 Develop a protocol to identify clusters versus outbreaks; manage and evaluate response to TB outbreaks and ensure a timely and seamless approach to TB outbreak management. *(Lead agencies: Office of the Provincial Health Officer and BCCDC)*
- 2.2 Increase the use of the standardized contact tracing approach outlined in the BCCDC TB Control Manual. *(Lead agencies: BCCDC and Regional Health Authorities)*

3. Improve tuberculosis literacy.

- 3.1 Develop TB literacy programs targeted towards foreign-born Canadians from TB-endemic countries, Aboriginal peoples, socially marginalized people, and those at high risk for TB who are under clinical care. *(Lead agencies: Regional Health Authorities)*
- 3.2 Broaden provincial awareness of TB and reduce associated stigma through community strategies including the promotion of regular events such as World TB Day (March 24th), Aboriginal-specific events and annual health/services fairs for new immigrants put on by MOSAIC and SUCCESS. *(Lead agencies: Regional Health Authorities)*
- 3.3 Work with organizations that support or represent at-risk groups to identify the most effective communication tools. *(Lead agencies: Regional Health Authorities)*
- 3.4 Identify existing TB educational programs for health care practitioners that may be adapted for use in BC, including:
 - developing an annual brief TB newsletter (electronic or hard copy) for physicians
 - leveraging a broad range of communication tools, e.g. Clinical practice guidelines, CME opportunities, posters, appropriate reminders/prompts on lab requisitions and lab results
 - developing a process whereby a physician is contacted after a TB diagnosis to review TB treatment protocol and resources, and
 - developing an online occupational health and safety TB course.*(Lead agency: BCCDC)*
- 3.5 Identify existing TB information toolkits for patients, their caregivers, and communities to:
 - increase knowledge about TB, the link between TB and other chronic diseases, TB treatment, and TB transmission
 - raise awareness that TB is a serious but treatable disease
 - promote appropriate screening, testing and intervention
 - give patients confidence that they can complete TB treatment and be cured
 - educate caregivers and families about how to support TB patients
 - promote an accepting attitude for people who have TB to reduce stigma attached to TB
 - eliminate the fear that they may be deported (if they are an immigrant or refugee)*(Lead agency: BCCDC)*
- 3.6 Collaborate with provincial corrections to develop client-centred education for inmates. *(Lead agencies: Regional Health Authorities and BCCDC)*

- 3.7 Work with the University of BC to develop a module about TB for the Intercultural Online Network (iCON). *(Lead agency: BCCDC)*
- 3.8 Where possible, integrate TB education into existing material or programs for associated diseases, e.g. the Advocacy for Hepatitis Care and Support Workbook. *(Lead agencies: Regional Health Authorities)*
- 3.9 Ensure that written materials are available in a variety of languages that reach new immigrants. *(Lead agencies: Regional Health Authorities)*
- 3.10 Engage in discussions with the Métis Nation to include information about TB in the National Métis Nation Health Action Plan. *(Lead agency: BCCDC)*
- 3.11 Offer information sessions to Aboriginal and immigrant-serving organizations on new scientific evaluations, treatments, diagnostics, best practices and the provision of medication. *(Lead agencies: Regional Health Authorities)*
- 3.12 Set up educational opportunities in areas frequented by socially marginalized people, e.g. social service agencies, soup kitchens and street level clinics. *(Lead agencies: Regional Health Authorities)*
- 3.13 Leverage the use of existing web-based and telephone services (e.g. #8-1-1) to communicate and educate broadly about TB. *(Lead agencies: Regional Health Authorities)*
- 3.14 Finalize and disseminate the TB program background papers that were developed to inform this strategic plan (see list in Appendix D). *(Lead agency: BCCDC)*

4. Align roles and responsibilities of the BCCDC and the regional health authorities with respect to service delivery within each region.

- 4.1 Using the BCCDC TB Manual and the roles and responsibilities described on page 11 as a starting point, each regional health authority and the BCCDC will develop service level agreements that define service level and resource allocation expectations of each party, including lab efficiencies. *(Lead agencies: Regional Health Authorities and BCCDC)*

5. Establish a tuberculosis scientific evaluation agenda that includes the socio-cultural aspects of TB service delivery and uptake.

- 5.1 Develop monitoring and scientific evaluation priorities and review them biannually. *(Lead agencies: Regional Health Authorities and BCCDC)*
- 5.2 Identify the direct health costs and indirect costs of TB in BC to inform decisions regarding planning for TB. *(Lead agency: BCCDC)*
- 5.3 Develop a mechanism for sharing monitoring and evaluation results with stakeholders. *(Lead agency: BCCDC)*
- 5.4 Identify sources of funding and opportunities for TB related scientific evaluation e.g. BC Lung Association, Michael Smith Foundation, and universities. *(Lead agency: BCCDC)*

- 5.5 Review how outreach is currently done to determine if it is effective. *(Lead agencies: Regional Health Authorities and BCCDC)*
- 5.6 Review public health capacity to deal with TB in rural and remote communities. *(Lead agencies: Regional Health Authorities)*
- 5.7 Enhance the molecular and genomic-based infrastructure, as well as other resource requirements, to enable the scientific evaluation and evaluation capacity of the Provincial Public Health Labs. *(Lead agency: Provincial Public Health Microbiology and Reference Laboratory)*

Strategic Goal 5 - Ensure state-of-the-art public health laboratory and clinical programs for the diagnosis, treatment and prevention of tuberculosis.

OBJECTIVES and ACTIONS:

1. Maintain a strong, centralized resource of tuberculosis expertise in BC.
 - 1.1 Recruit, support, and retain clinical and laboratory experts in TB. *(Lead agencies: BCCDC and Provincial Public Health Microbiology and Reference Laboratory)*
2. Improve diagnosis of active and latent tuberculosis.
 - 2.1 Develop the BC Public Health Lab Network to empower work with regional health authority microbiology labs on better testing (for both TB and LTBI cases). *(Lead agency: Provincial Public Health Microbiology and Reference Laboratory)*
 - 2.2 Support improvements needed to provide an appropriate level of enhanced molecular testing. *(Lead agency: Provincial Public Health Microbiology and Reference Laboratory)*
 - 2.3 Assess the provincial diagnostic laboratory system related to TB to determine if services for public health, surveillance, infection control and patient care are optimal. *(Lead agency: Provincial Public Health Microbiology and Reference Laboratory)*
 - 2.4 Link to existing methods of systematically approaching new technology assessments, their application to screening and diagnostics, and making recommendations (e.g. Canadian Agency for Drugs and Technologies in Health). *(Lead agency: Provincial Public Health Microbiology and Reference Laboratory)*
 - 2.5 Develop a business case for broader implementation of interferon gamma release assay (IGRA) and make recommendations to support policy development. Issues to be considered include, but are not limited to:
 - how IGRA testing will be used to screen populations with specific vulnerabilities,
 - the use of IGRA for the general population,
 - the use of IGRA if there is a tuberculin skin test (TST) cluster in an institution,
 - the point in the clinical pathway at which IGRA testing should be used, and
 - funding for IGRA testing.

(Lead agency: BCCDC and Provincial Public Health Microbiology and Reference Laboratory)

- 2.6 Implement the use of tests which detect drug resistance early in diagnosis *(Lead agency: BCCDC and Provincial Public Health Microbiology and Reference Laboratory)*

3. Improve treatment of tuberculosis.

- 3.1 Use, develop or update guidelines for TB treatment adherence, including:

- when to use DOT
- guidelines for responding to people at high risk for non-adherence
- the use of cell phones, email, and social media
- the appropriate use of family, friends or peers

(Lead agency: BCCDC)

- 3.2 Incorporate DOT TB treatment into other drug treatment platforms, e.g. for HCV, HIV, STIs, and the provision of methadone. *(Lead agencies: Regional Health Authorities)*

- 3.3 Expand the use of lay community health workers as liaisons between the nurse and the patient to do confidential outreach for Aboriginal people who live off-reserve. *(Lead agencies: Regional Health Authorities)*

- 3.4 Explore the feasibility of including TB in the provincial Chronic Disease Management Initiative. *(Lead agency: Ministry of Health)*

- 3.5 Ensure that the information supporting the management of multi-drug resistant TB (MDRTB) is up to date and that the information is communicated and clearly understood by health care practitioners. *(Lead agency: BCCDC)*

- 3.6 Explore opportunities to allocate resources to improve management of TB in high risk populations *(Lead agency: BCCDC and Regional Health Authorities)*

4. Improve continuity of care for hospitalized patients and inmates of correctional institutions.

- 4.1 Ensure that hospitals, correctional facilities, and public health work together to put community follow-up plans in place prior to individuals being discharged or released. *(Lead agencies: Regional Health Authorities)*

Glossary

Aboriginal: Aboriginals are considered all Indigenous people of Canada, including Status and Non-Status Indian, Métis and Inuit people. Indigenous has been interchanged with Aboriginal, Native, Native Peoples and First Peoples, and is generally used internationally. The term Aboriginal should always be capitalized.

Active TB: Refers to TB infection in any part of the body that has become symptomatic, but does not imply whether there is any risk of transmission. This is also known as TB disease.

Cluster: an unexpected grouping in time, place or population of disease; also refers to an outbreak in a defined group.

Control: in context of when an outbreak is under control, control means returning to the baseline incidence (normal) for that population.

Directly Observed Therapy (DOT): Directly Observed Therapy (DOT) is the process whereby the ingestion of every dose of medication is directly observed in order to improve a patient's ability to adhere to a complex or challenging medication regimen.

First Nation(s): The term First Nations came into common usage in the 1970s to replace band or Indian, which some people found offensive. Despite its widespread use, there is no legal definition for this term in Canada. The term First Nation should always be capitalized.

First Nations People - Many people prefer to be called First Nations or First Nations People instead of Indians. The term is not a synonym for Aboriginal Peoples because it doesn't include Inuit or Métis. The term First Nations People generally applies to both Status and Non-Status Indians.

First Nation - Many bands started to replace the word band in their name with First Nation in the 1980s. It is a matter of preference by individual First Nations/bands.

Health Promotion: the process of enabling people to increase control over, and improvement of their health.

Incidence rate: the rate of new events occurring in a population of a given size. The numerator is the number of new events that occur in a defined period, the denominator is the population at risk of experiencing the event during this period.

Infection Control: the discipline concerned with preventing infection in health care settings.

Infectious TB: An active TB infection that is transmissible to others.

Latent TB: TB infection that persists in a host without evidence of clinically active disease or transmission risk.

Outbreak: a higher incidence of a disease than normally expected in specified timeframe, place and or population.

Prevalence: the number of people with disease in a given population at a specified time.

Primary Prevention: actions aimed at reducing the incidence of disease in a population

Public health surveillance: ongoing and systematic collection, analysis and interpretation of health-related data essential to the planning, implementation, and evaluation of public health practice. [WHO]

Pulmonary TB: a TB infection of the lungs and conducting airways; the only site of infection that is commonly infectious and transmissible to others.

Screening: the identification of unrecognized disease risk in apparently well persons by the application of tests and or examinations.

Sensitivity: is the proportion of truly diseased persons in a screened population who are identified as diseased by the screening test, true positive rate.

Specificity: is the proportion of truly non-diseased persons who are identified by the screening test; true negative rate.

Surveillance: ongoing observations to detect changes in trend or distribution of a health/disease/death issue in order to initiate investigation and or control measures.

TB Disease: see Active TB.

Appendices

APPENDIX A: LIST OF TB CONSULTATION SESSIONS

APPENDIX B: HIGH LEVEL OUTLINE OF AN OUTBREAK IDENTIFICATION, MANAGEMENT AND REVIEW PROTOCOL

APPENDIX C: AREAS OF SCIENTIFIC EVALUATION IDENTIFIED DURING THE TB CONSULTATION SESSIONS

APPENDIX D: LIST OF TB STRATEGIC PLAN BACKGROUND PAPERS

Appendix A: List of TB Consultation Sessions

During the spring of 2011, 34 TB discussion sessions were held with health authority front-line and management staff, and representatives from governmental and non-governmental organizations including the Aboriginal community, Health Canada, immigrant serving organizations, organizations engaged with HIV/AIDS and federal and provincial corrections. In total over 100 individuals participated in the discussion sessions.

Discussion session participants provided the project team with numerous ideas and suggestions. Feedback was recorded and common themes were incorporated into the strategic plan and stakeholders had an opportunity to review the draft strategy.

The project team wishes to extend its sincere appreciation to all those who participated in the discussions and shared their commitment, energy, and enthusiasm.

Federal and Provincial Government

Health Canada - First Nations Inuit Health Branch
BC Ministry of Health
Office of the Provincial Health Officer
Citizenship and Immigration Canada
Correctional Service of Canada
Ministry of Public Safety and Solicitor General, British Columbia Corrections Branch

Provincial Health Services Authority

BC Centre for Disease Control – TB Prevention and Control
BC Public Health Microbiology and Reference Laboratory
BC Cancer Agency
BC Children's Hospital and Sunny Hill Health Centre for Children
BC Women's Hospital & Health Centre
BC Provincial Renal Agency
BC Transplant
BC Mental Health & Addiction Services

HIV/AIDS

BC Centre for Excellence in HIV/AIDS
Pacific AIDS Network (PAN)
Positive Living North

Immigrant Serving Agencies

MOSAIC
SUCCESS
Progressive Intercultural Community Services

Health Authorities

Fraser Health Authority
Vancouver Island Health Authority
Interior Health Authority
Northern Health Authority
Vancouver Coastal Health Authority

Aboriginal Organizations

BC Association of Aboriginal Friendship Centres
Métis Nation of BC
Inter Tribal Health Authority
Nuu-chah-nulth Tribal Council

Other Stakeholders

University of BC – School of Population and Public Health
BC Lung Association
Patient Voices Network
Public Health Association of BC
WorkSafe BC

Appendix B: High-level Outline of an Outbreak Identification, Management and Review Protocol

The Outbreak Identification, Management and Review Protocol will include but is not limited to the following:

- Principles that are the foundation of the approach, e.g.
 - Integrated case management.
- Definitions that explain the difference between an emergency, a cluster, and an outbreak, what it means to 'control' an outbreak.
- The triggers/red flags for when to initiate a phone call or meeting because of a possible outbreak.
- Whose responsibility it is to declare an outbreak.
- The triggers for when to start outbreak control.
- Key processes/steps in an outbreak, e.g.
 - The regional health authority staff and the BC PHMRL to CDC for a briefing and planning session.
 - Identify any new partners specific to the outbreak, e.g. employers of migrant workers if outbreak concentrated in that population; immigrant serving societies if outbreak concentrated in a particular group.
- Clearly defined and documented roles and responsibilities of all stakeholders (use BC Emergency Response Management System as a possible model).
- Expected costs/areas of cost
 - How funding will be handled when costs are beyond the base budget.
- Resources/capacity
 - How to assemble and outbreak team [*Nuu-chah-nulth Tribal Council has an example*]
 - How to ensure clinical, public health, and laboratory surge capacity
 - Key aspects of flexible resourcing for outbreaks.
- Challenges in an outbreak, e.g.
 - Finding possible contacts for testing purposes – the use of network analysis to find the 'nodes' where people go where there is not TB presence, i.e. soup kitchens
- Outbreak control for cluster outbreaks
 - Note: Cluster implies the same organism (genotyping; molecular genotyping) and showing recent transmission. This shows importance of early contact tracing.
 - Define and support the role of the BC-PHMRL and its networks in the epidemiological aspect of detecting and characterizing TB.
 - Define the need to provide molecular characterization of all TB strains.
 - Define how BC-PHMRL can use GIS to communicate laboratory molecular epidemiology data.
 - Epidemiological support for mapping transmission.
- Communication channels including:
 - Clarifying who interacts with the media

- Communication between the Lab and others
 - Communication with partners, e.g. emergency room doctors
- Data sharing
 - Developing a database for the purposes of the outbreak; use outbreak software if available
 - What data is shared, when, and by/to, whom
- Statement of criteria for determining that an outbreak is over, e.g. returning to the background level is not necessarily a good criteria
- Clear process for gathering 'lessons learned' at the end of the outbreak, including:
 - Meetings to de-brief including a discussion as to why the smear positive cases were missed.
 - Written documentation of the outbreak, issues, and lessons learned
 - Process to modify the template for next time
- Final outbreak documentation
 - All outbreaks should be written up and shared

Appendix C: Areas of scientific evaluation identified during the TB Consultation Sessions

The following ideas were identified during the TB Discussion Sessions as possible areas for scientific evaluation:

- scientific evaluation on the value of conducting baseline screening for entire groups of workers
- what lessons can we learn from the First Nations communities whose incidence of TB is now much closer to the incidence for non-First Nations people
- focused study on which people reactivate in the first five years after emigrating to Canada to identify risk factors and help support targeted screening
- qualitative scientific evaluation on how to improve adherence to the TB treatment
- review scientific research on populations at high risk for non-compliance in order to ensure that the treatment approach is based on the best evidence
- scientific evaluation to develop a cost-effective TB test with high levels of specificity and sensitivity
- support ongoing work around rapid quantitative molecular tests for TB that have the potential to replace traditional acid-fast smears
- scientific evaluation into modelling the utility of implementing decentralized rapid molecular testing (Cepheid Gene Xpert) for TB across BC (in progress)
- scientific evaluation into molecular tests for detection of MDR-TB and other drug resistant forms of TB
- evaluate the usefulness of universal genotyping of all TB isolates and sharing of data with other provincial and national partners
- applying genomics-based methods for tracking TB transmission within outbreaks
- support analysis of new tools for surveillance
- participating in multi-centre scientific research, nationally and internationally, to address the question of the role of IGRA testing in paediatric TB
- ethical issues associated with TB treatment
- what type of health promotion is most effective
- scientific evaluation on effective methods to reduce stigma
- undertake epidemiological and laboratory scientific research on TB in each regional health authority in partnership with necessary partners (Provincial Public Health Laboratory, community workers, etc) to inform program delivery
- evaluate whether the current TB Control program is having an effect among overall prevalence rates in immigrants
- evaluate the effectiveness of integrated service delivery including the provincial laboratory network
- review how outreach is currently done to determine if it is effective
- review the Public Health capacity to address these public health issues in rural and remote communities
- Enhance the capacity of the Provincial Public Health Microbiology & Reference Laboratory to undertake scientific evaluations

Appendix D: List of TB Strategic Plan Background Papers

The following background papers are available upon request from the BCCDC:

Background paper #1 – Overview of current TB situation: Globally, in Canada, and in BC

Background paper #2 – Organization of TB Service Delivery in BC: Partnerships and Integrated Responsibilities

Background paper #3 – Active Case Management: Prompt Diagnosis and Effective Treatment

Background paper #4 – Surveillance; Outbreak Detection and Management; Infection Control; and Contact Tracing

Background paper #5 – Targeted Testing and Treating of LTBI

Background paper #6 – Enhanced Strategies for Vulnerable Demographic Groups

Background paper #7 – Contributing to Global TB Control Efforts

Background Paper #8 – Role of the British Columbia Public Health Laboratory and Its Networks for the Diagnosis, Management, Prevention and Control of TB

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #: 908529

PREPARED FOR Minister Michael de Jong, QC, Minister of Health
Minister Don McRae, Minister of Agriculture - **FOR INFORMATION**

TITLE: Overview of the Outcome of the BC Abattoir Inspection Review

PURPOSE: To provide information on the nine recommendations and two proposed options for a new provincial meat inspection system. Joint Minister's briefing scheduled for January 9, 2012.

BACKGROUND:

In the spring of 2010, government requested a review of the meat inspection system for provincially licensed Class A and B slaughter plants to identify potential modifications and alternatives. In response, the Ministry of Health (MoH) established a steering committee to lead the BC Abattoir Inspection System Review (BCAISR). Government directed that a new system will need to effectively ensure meat safety, livestock health and welfare, support the BC meat industry and be sustainable.

In the fall of 2010, the Canadian Food Inspection Agency (CFIA), which currently provides inspection services in BC, announced it would cease to provide inspection services in provincial plants on January 1, 2014. Three provinces including BC are affected by this decision. This announcement focused the review on identifying options for a new provincial inspection system. The review included research and consultations with stakeholders and meat inspection experts.

A report was developed to present the findings of the review that lays out nine recommendations for a future provincial meat inspection system, two potential system designs and advice for implementation. The report does not contain financial costing information.

DISCUSSION:

S. 13, S. 17

S. 13 S. 17

S. 13, S. 17

ADVICE:

S. 13

Program ADM/Division: Arlene Paton, ADM, Population and Public Health

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Program Contact: Tim Lambert, Executive Director, Health Protection

Drafter: Lorie Hryciuk, Director Food Protection

Date: December 30, 2011

File Name with Path: Z:\Deputy Minister\Briefing Documents\2011\1. Approved 2011\PH\908529 - Overview of Outcome of BC Abattoir Inspection Review MO Joint Bfing Jan 9.docx

B.C. Abattoir Inspection System Review

Presentation to Ministers of Health and Agriculture

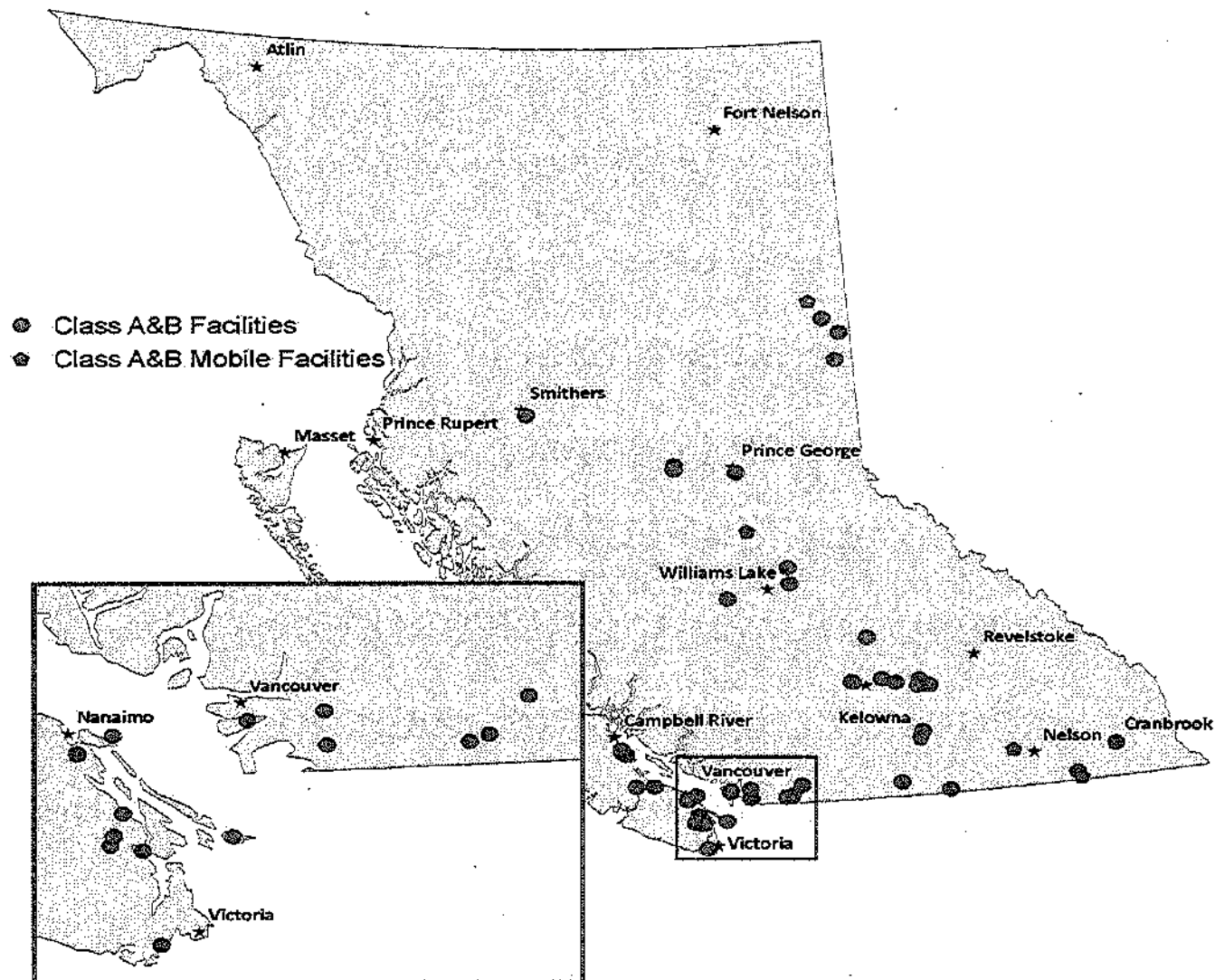


Presentation Overview

- BC's Existing Meat Inspection System
- The BC Abattoir Inspection System Review (Review)
 - Structure & activities of the Review
- Overview of the Review Outcomes:
 - Key review findings
 - Recommendations for a future meat inspection system
 - Proposed meat inspection system options
- Next Steps



Provincially Licensed Class A and B Plants



BRITISH
COLUMBIA

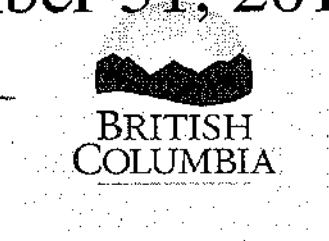
BC's Existing Meat Inspection System

- Regulated by BC Meat Inspection Regulation (2004) to promote production of safe local meat
- The Province contracts CFIA for inspection
- Inspector inspects every animal/flock and all carcasses; oversees every slaughter
- Abattoirs may not operate without inspector present
- No training required of operators or staff
- Regulation requires operator maintains a food safety plan



Drivers of the Review

- Direction from government to identify alternatives to the existing provincial meat inspection system
- Government committed to paying cost of inspection until 2012; recommendation is to continue funding until new inspection system is in place
- Ranching Taskforce recommendations:
 - The Province continue to pay for the cost of inspection
 - The inspection system be made more responsive to the needs of operators
- CFIA will no longer provide provincial inspection services after December 31, 2013



Key Objectives

The Steering Committee was asked to identify options for a provincial meat inspection system that:

- maintains or improves existing provincial standards for meat safety in provincially licensed abattoirs
- responds to the needs of B.C.'s meat industry
- operates in a cost-effective manner
- maintains or improves the standards and practices for animal health and welfare



Review Activities Included

1. Four phases of stakeholder consultation
2. Consultation with advisory group of public health and meat inspection experts
3. Consultation with an advisory group of provincial abattoir operators
4. Review primary and secondary research on meat inspection practices and meat inspection systems



Review Scope

IN SCOPE	OUT OF SCOPE
• Overall design of provincial meat inspection system in Class A & B licensed plants • Ante mortem, post mortem & facility inspections, oversight of slaughter practices as set out in the BC Meat Inspection Regulation • Examination of other jurisdictions and sectors	• Financial costs of potential systems • Technical inspection standards • Plant construction standards • Meat processing activities • Class D & E licenses • Issues of federal jurisdiction: --International trade, inter-provincial trade, SRM waste management, etc.



Key Review Findings

The future provincial meat inspection system should:

- Improve the rigour and oversight of food safety plans
- Improve knowledge of abattoir staff regarding best practices for meat safety, animal health and welfare
- Increase levels of oversight over plant performance and of the inspection system as a whole
- Provide flexibility to meet diverse operator needs
 - ie. greater scheduling flexibility vs. greater market access
- Improve system transparency and responsiveness



Pages 266 through 273 redacted for the following reasons:

S. 13

Budget Implications

S. 13, S. 17



Page 275 redacted for the following reason:

S. 13

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff 920458

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

TITLE: Food & Consumer Products of Canada Meeting

PURPOSE: To provide information on Food & Consumer Products of Canada for Minister's meeting scheduled for April 24, 2012 at 3:15 pm

BACKGROUND:

Food & Consumer Products of Canada (FCPC) is the national industry association in Canada representing the food and consumer products industry. Member companies range from small independently and privately-owned companies to large, global multinationals all of whom manufacture and distribute in Canada. The vision of FCPC is to be the most influential voice of the Canadian food, beverage and consumer products industry. The food and beverage industry is the largest manufacturing sector in Canada, employing close to 300,000 people, including almost 25,000 British Columbians. Please see Appendix A for further background on FCPC.

FCPC has previously noted their commitment to work in partnership with provincial governments to address issues related to healthy living and has acknowledged the Canadian food industry's responsibility in contributing to the health and wellness of Canadians.

The BC Ministry of Health has a strong presence on Federal/Provincial/Territorial (FPT) Task Groups. British Columbia continues to support a national approach to reducing the dietary sodium intake of Canadians and is engaged in leading FPT work to implement recommendations from the *Sodium Reduction Strategy for Canada*. BC launched a sodium reduction education and awareness campaign in July 2011, with a second wave in December 2011, using nationally developed sodium reduction messages. Other sodium reduction activities include establishing sodium targets and procurement policies in health care facilities, and expanding and enhancing Dietitian Services at HealthLink BC. FCPC is actively participating in efforts to lower Canadians' intake of dietary sodium through development of "healthier for you" product choices.

BC is also engaged in leading FPT collaboration on actions to curb childhood obesity. In March 2011, the Federal Government, in partnership with provinces and territories, launched a national conversation, *Our Health Our Future*, with youth, caregivers, governments, non-government organizations, industry and citizens to identify shared approaches to reversing the serious issue of the growing rate of childhood overweight and obesity. FCPC provided a submission and participated in *Our Health Our Future*. FCPC is incorporating a number of strategies to help Canadians manage their caloric intake, including changes to packaging size.

The BC Government recognizes that combating obesity requires changes to the built environment, more opportunities for physical activity, and increased accessibility of healthy food. Healthy Families BC aligns with the FPT framework for action and targets investments and efforts in initiatives that will measurably address physical inactivity, unhealthy eating, and obesity.

The Office of the Provincial Nutritionist has been in regular contact with FCPC, as with other industry stakeholders, to provide updated progress on the review and revision of the Guidelines for Food and Beverage Sales in BC Schools (BC Guidelines). BC will be consulting (in 2012) with FCPC and other industry stakeholders as part of the process of reviewing and revising the BC Guidelines. FCPC is aware that the original timeline for the review of the BC Guidelines has been delayed due to the job action with the education sector. FCPC is also aware that BC continues to support the Provincial/Territorial work to improve consistency of school food guidelines across jurisdictions.

DISCUSSION:

The Healthy Families BC healthy eating initiatives have required strong partnerships, collaboration and commitment to action across multiple sectors.

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Healthy Families BC is creating environments in schools, workplaces and community settings that support individuals and families to make healthy choices.

ADVICE:

The meeting with FCPC provides an opportunity to reinforce BC's commitment to sodium reduction and promotion of healthy weights. BC will continue to move forward with initiatives that focus on creating healthy food environments where British Columbians live, work, learn, and play. FCPC's efforts are appreciated and the Province looks forward to opportunities for future engagement with their members.

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Date:	April 11, 2012
File Name with Path:	P:\CDIPBEHL_CD Prevention\Briefing Notes - 280-20\2012 - Briefing Notes\CDIPBE\920458 - Food And Consumer Products Of Canada - Meeting April 24, 2012.Docx

Page 210 to/à Page 229

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 921242 (x-Ref #920122)

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

TITLE: Meeting with Prevention of Violence Canada

PURPOSE: To advise the Minister of Health about the result of the meeting with Prevention of Violence Canada-Prévention de la violence Canada regarding S. 13, S. 17, S. 21 the World Health Organization's 6th Milestones Meeting of the Global Campaign for the Prevention of Violence.

BACKGROUND:

Prevention of Violence Canada-Prévention de la violence Canada (PVC), represented by Shannon Turner, requested a meeting with the Minister of Health on February 16, 2012, S. 13, S. 17 World Health Organization's (WHO) 6th Milestones Meeting in early March 2013, in either S. 17 Ministry of Health's (MoH) Assistant Deputy Minister, Population and Public Health Division, and her staff met with PVC on March 23, 2012.

S. 17 Milestones Meeting will take place in Germany and results will be finalized at the end of April. In the meantime, PVC is establishing a leadership forum in BC to assist S. 17 and advised MoH on the status of support from other agencies. PVC is requesting the involvement of the following ministries in the leadership forum: Health, Education, Housing, Justice, Aboriginal Relations and Reconciliation, and Children and Family Development.

The Canadian delegation that attended the 2011 5th Global Milestones Meeting in Capetown, South Africa, has had preliminary meetings with WHO and there is interest in Canada as a host nation. To date, PVC has support for S. 17 to host the Meeting from the Public Health Association of BC, Canadian Public Health Association (CPHA), SMARTRISK, Canadian Red Cross Society, the Centre for Addiction and Mental Health, and the Centre for Disease Control in Atlanta, Georgia. Shannon indicated that Premier Clark wrote to PVC and has directed the new Provincial Office of Domestic Violence to follow up. A copy of the Premier's letter is attached (Appendix A).

The WHO Global Prevention Alliance organizes the Milestones Meetings every two years to bring national and international non-government organizations and researchers together to address violence prevention. It is usually attended by about 300 invited delegates.

DISCUSSION:

While the event is hosted by WHO, BC could have a role in the agenda and ancillary events open to wider participation may be organized.

PVC regards the Milestones Meeting as a strategic opportunity to highlight BC's inter-ministry cooperation and showcase BC's work on violence prevention. BC is recognized as a leader in public health in Canada on the issue of violence prevention through the core public health model program on the Prevention of Violence, Abuse and Neglect. WHO has lauded BC for its extraordinary whole of government approach to prevention and health promotion.

WHO covers the majority of costs for the Milestones Meetings. Currently, S. 17

S. 17

ADVICE:

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Program ADM/Division:	Arlene Paton/Population and Public Health
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Program Contact:	Joan Geber, Executive Director, Healthy Women, Children and Youth Secretariat
Drafter:	Sara McLaughlin, Manager, Women's Health, Healthy Women, Children and Youth Secretariat
Date:	March 26, 2012
File Name with Path:	Z:\Healthy Women, Children and Youth Secretariat\Briefing Notes\WOMEN'S ISSUES (280-20 BN)\2012 (280-20 BN)\921242 - Prevention of Violence Canada's Bid on 2013 WHO Prevention of Violence Conference.doc

Prevention of Violence Canada
Prévention de la violence Canada



February 16, 2012

Honourable Michael de Jong, Q. C.
Minister of Health
Province of British Columbia
Room 337
Legislative Buildings
Victoria, British Columbia V8V 1X4

MINISTER'S OFFICE HEALTH	
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FYI ☐	REPLY DIRECT ☐
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FILE ☐	
REMARKS	
☐ AA	☐ MA
☐ EA	☐ CCU
	☐ SA
	☐ DM

Dear Minister de Jong:

Held every two years, The World Health Organization Global Violence Prevention Alliance brings national and international NGO's and researchers together to address violence prevention issues across the globe. Leading researchers and international advocates participate in the Alliance and Canada has been a strategic partner for many years.

Prevention of Violence Canada/Prevention de la Violence Canada is preparing

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The Canadian Delegation to Capetown, South Africa has had preliminary meetings with WHO on this matter and there is interest in

s. 17

the event is hosted by WHO.

s. 17

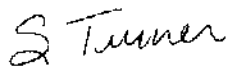
s. 17

We are pulling together a provincial team to work with the National Coalition to help us
s. 17 With the model core program on the Prevention of Violence, Abuse and Neglect, British Columbia is a recognized leader in public health in Canada on this issue. British Columbia has been recognized by WHO for its extraordinary "whole of Government approach" to health issues. This meeting is a strategic opportunity to highlight cooperation between Ministries, and civil society to address violence in our province.

.../2

We are aware and most supportive of the Premier's leadership for the Sun anti-bullying campaign and see this event as a continuation of that commitment to safe communities in British Columbia. We are requesting the assistance of the Ministries of Health, Education, Housing, Justice, Aboriginal Relations and Reconciliation, and Children and Family Development. We are also aware of the effective collaboration between the Minister of Education, Honourable George Abbott and NDP MLA John Horgan for their joint work in reaching solutions for school health and safety. It is this type of cooperative governance that exemplifies civic leadership in British Columbia. We would like to arrange a meeting with you to discuss this potential commitment and its consequent opportunities.

Sincere regards,



Shannon Turner
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cc: Marjorie MacDonald, PhD, President, Public Health Association of BC

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #: 917857

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

TITLE: Raw Milk and Raw Milk Cheese

PURPOSE: To provide background on the legislation and rationale prohibiting the sale of unpasteurized (raw) milk and raw milk cheeses.

BACKGROUND:

- Current federal and provincial legislation prohibits the sale of unpasteurized (raw) milk in British Columbia. Please see Appendix 1 for an overview of the relevant federal and BC statutory provisions.
- The link between consumption of raw milk and disease has been well established for several pathogenic organisms (e.g., *E. coli*, *Campylobacter*, *Listeria*, *Salmonella* and *Staphylococcus*), and raw milk is pasteurized primarily to destroy pathogenic bacteria that may be present. Please see Appendix 2 for a summary of diseases from raw milk.
- Consuming raw milk presents a serious health hazard, and may result in mild illness, long-lasting serious disease, or even death, particularly among vulnerable populations including young children, immune-compromised individuals, seniors, and pregnant women.
- It is extremely difficult for a consumer to determine if raw milk is contaminated with dangerous pathogens; indeed, even raw milk with a normal appearance from apparently healthy cows can contain pathogenic bacteria with the potential to cause human illness.
- Raw milk can be sold legally in 29 of the 50 U.S. states. However, this does not mean it is safe to consume. While all of these 29 states have testing and inspection programs for certifying raw milk dairy farms, outbreaks and recalls associated with certified raw milk dairy farms continue to occur on a regular basis. Please see Appendix 3 for a summary of raw milk outbreaks in North America from 2000 to 2011.
- Licensed BC dairy processing plants can legally use unpasteurized milk to produce hard and semi-hard cheese in compliance with the federal *Food and Drugs Act*. Such cheese must be aged for a minimum of 60 days under controlled, refrigerated conditions. The majority of pathogens initially present in the raw milk are destroyed during this aging period, though *Listeria* growth may be enhanced. As well, these dairy processing plants are subject to regulatory oversight, inspection, and rigorous standards. Please see Appendix 1 for an overview of the relevant federal and BC statutory provisions.

DISCUSSION:

- Pasteurization of raw milk simply heats the milk to or above a minimum temperature for a prescribed minimum time to kill the disease causing pathogenic bacteria – exactly the same type of process as when one cooks poultry or meat to kill any disease causing bacteria that

may be in those products. Only vitamins A and D are added to pasteurized fluid milk to replace those natural vitamins that are reduced when a portion of the butterfat (cream) is removed to make lower fat fluid milk products. No other additives or preservatives can be legally added to fluid milk.

- Although consumption of raw milk in BC is very low (due to legislation prohibiting its sale), there have been several outbreaks caused by the consumption of raw milk in BC. Please see Appendix 4 for a summary.
- There continues to be high risks from consuming raw milk as evidenced by the number of outbreaks occurring in North America, particularly in those U.S. states that permit the sale of raw milk to the public. Such states have a higher incidence of outbreaks than states that prohibit the sale of raw milk; moreover, in cases where age was known, a higher proportion of those involved were under the age of 20. Where children have become ill from the consumption of raw milk, it is often the case that these children were given the raw milk by well-intentioned parents.
- Regarding the purported 'healthiness' of raw milk, there is no credible or scientific evidence that consumption of raw milk produces any measurable health benefits.
- Health Canada is currently proposing to amend the *Canadian Food and Drug Act* and regulations to permit the production of soft cheese made from raw milk without aging across the country. This direction is as a result of the province of Quebec expressing a desire to produce these products. Quebec received special authorization from Health Canada in 2008 to permit and regulate this activity. BC's current position, which is shared by the BC Centre for Disease Control and the Ministries of Health and Agriculture, is that the production and processing of soft cheese itself does not significantly reduce pathogen levels. As such, making soft cheese with raw milk without aging is similar to drinking raw milk from a human health risk viewpoint.

ADVICE:

The advice to the general public is that the risk of disease from consuming raw milk is high. The current legislation prohibiting the sale of raw milk in BC is appropriate.

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Drafter:	David Travia, Policy Analyst
Date:	February 24, 2012
File Name with Path:	I:\Health Protection\Protection\BRIEFING NOTES\2012\917857 Raw Milk & Cheese\917857 Raw Milk and Raw Milk Cheese.docx

APPENDIX 1

Overview of the Relevant Federal and B.C. Statutory Provisions Regarding Raw Milk

The B.C. *Public Health Act* prohibits a person from causing a health hazard, and makes it an offence to cause a health hazard.

Public Health Act

Definitions

"health hazard" means

- (a) a condition, a thing or an activity that
 - (i) endangers, or is likely to endanger, public health, or
 - (ii) interferes, or is likely to interfere, with the suppression of infectious agents or hazardous agents, or
- (b) a prescribed condition, thing or activity, including a prescribed condition, thing or activity that
 - (i) is associated with injury or illness, or
 - (ii) fails to meet a prescribed standard in relation to health, injury or illness;

Must not cause health hazard

15 A person must not willingly cause a health hazard, or act in a manner that the person knows, or ought to know, will cause a health hazard.

Duties of operators

- 18**
- (1) An operator who engages in a regulated activity must take reasonable care to
 - (a) prevent health hazards from arising in the course of the regulated activity, and
 - (b) respond to health hazards that arise, including mitigating harmful effects of the health hazard.
 - (2) An operator who is an employer must ensure that employees are adequately trained and sufficiently equipped to recognize, prevent and respond to health hazards that may arise when engaging in a regulated activity.
 - (3) An operator who engages in a regulated activity must comply with any requirement or duty set out in a regulation respecting the regulated activity.

The B.C. *Public Health Act* Transitional Regulations prescribe unpasteurized milk as a health hazard

Public Health Act Transitional Regulations

Health Hazard Regulation (unpasteurized milk)

7 Milk for human consumption that has not been pasteurized at a licensed dairy plant in accordance with the *Milk Industry Act* is prescribed as a health hazard.

In addition, the B.C. *Milk Industry Act* prohibits the sale/supply of unpasteurized dairy products. A person may still drink unpasteurized milk from his/her own cow.

Milk Industry Act

No sale of dairy products unless pasteurized

6 (1) A person must not sell, offer for sale or supply any dairy product unless the dairy product has been pasteurized in accordance with this Act and the regulations.

(2) Subsection (1) does not apply to cheese sold or offered for sale in compliance with the *Food and Drugs Act* (Canada).

(3) Dairy products are deemed to be for sale if

(a) contained in closed retail packages on the premises or the delivery truck of a vendor or producer vendor or in a retail store, unless conspicuously labelled "not for sale",

(b) delivered or shipped to a vendor in cans, or

(c) held in a farm holding tank in a milk house on a dairy farm where milk is regularly collected by means of a tank truck, unless it is conspicuously labelled "not for sale".

The federal *Food and Drug Act* does not permit the sale of raw milk that has not been pasteurized.

Food and Drug Regulations

B.08.002.2 (1) Subject to subsection (2), no person shall sell the normal lacteal secretion obtained from the mammary gland of the cow, genus *Bos*, or of any other animal, or sell a dairy product made with any such secretion, unless the secretion or dairy product has been pasteurized by being held at a temperature and for a period that ensure the reduction of the alkaline phosphatase activity so as to meet the tolerances specified in official method MFO-3, *Determination of Phosphatase Activity in Dairy Products*, dated November 30, 1981.

(2) Subsection (1) does not apply to

o (a) cheese; or

o (b) any food that is sold for further manufacturing or processing in order to pasteurize it in the manner described in subsection (1).

Unpasteurized milk may be used to produce cheese if it is aged for a minimum of 60 days under controlled, refrigerated conditions (any pathogens initially present are destroyed over this period).

Summary of Food Borne Illnesses & Outbreaks in North America Associated with the Consumption of Raw Milk and Raw Milk Dairy Products (2000-2011).

(Note: This table does not include raw milk cheeses that are aged >60 days)

45 Outbreaks:

- 686 illnesses (including 4 infected newborns)
- 34 hospitalizations
- 8 deaths (7 miscarriages/stillbirths)
- 14 developed hemolytic uremic syndrome (HUS)
- 2 developed Guillian-Barre syndrome

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
45	August – November 2011 Washington	<i>E. Coli</i> O157:H7	Licensed Raw Milk Dairy	3 illnesses 3 children 1 child hospitalized / developed HUS and died	Washington State DOH Food Safety Notice: November 23, 2011. Available at: http://www.doh.wa.gov/ehp/food/rawmilk-cozyvale.pdf . Accessed on February 22, 2012. <i>Food Safety News</i> January 03, 2012. Available at: http://www.foodsafetynews.com/2012/01/lawsuit-filed-in-washington-state-raw-milk-outbreak/ . Accessed on February 22, 2012.
44	August – October 2011 California	<i>E. Coli</i> O157:H7	Licensed Raw Milk Dairy	5 illnesses 5 Children 3 hospitalized / developed HUS	California Department of Agriculture News Release. November 15, 2011. Available at: http://www.cdfa.ca.gov/egov/Press_Releases/Press_Release.asp?PRnum=11-064 . Accessed on February 22, 2012.
43	September 2011 New York	<i>Campylobacter</i>	Licensed Raw Milk Dairy (Farm Gate)	2 illnesses	New York State DOH Release: January 29, 2010. Available at: http://www.health.ny.gov/press/releases/2010/2010-01-29_campylobacter_contamination_in_raw_milk.htm . Accessed on February 22, 2012. <i>WBNG News</i> <i>Campylobacter Contamination Found in Raw Milk in Tompkins County</i> September 29, 2011. Available at: http://www.wbng.com/news/around-the-tiers/Campylobacter-Contamination-Found-in-Raw-Milk-in-Tompkins-County-130820728.html . Accessed on February 22, 2012.

Summary of Food Borne Illnesses & Outbreaks in North America Associated with the Consumption of Raw Milk and Raw Milk Dairy Products (2000-2011).

(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
42	June 2011 North & South Carolina	<i>Campylobacter</i>	Licensed Raw Milk Dairy Farm Retail raw milk sale is permitted in South Carolina (no interstate commerce) Raw milk sales is not permitted in North Carolina	3 illnesses	US FDA Press Release July 16, 2011. Available at: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm263158.htm Accessed on February 22, 2012.
41	June 2011 Michigan	<i>Coxiella burnetti</i> (Q fever)	Raw milk Cow share	3 illnesses	Ann Arbor.com <i>Raw milk sickens two Washtenaw County women with Q fever</i> June, 23, 2011 http://www.annarbor.com/news/q-fever-from-raw-milk-sickens-two-washtenaw-county-women/ . Accessed on February 22, 2012.
40	May - June 2011 Alaska	<i>Campylobacter jejuni</i>	Raw milk Legal cow share	4 illnesses 1 child (Age range 1-81 yrs old)	State of Alaska Epidemiology Bulletin No.22, July 28, 2011. Available at: http://www.epi.alaska.gov/bulletins/docs/b2011_22.pdf Accessed on February 22, 2012.
39	May 2011 Michigan	<i>Campylobacter jejuni</i>	Raw milk	16 illnesses Raw milk purchased at farm and served at a school event. Outbreak strain matched clinical samples and that from farm bulk milk tank.	Journal Sentinel <i>Raw milk cause of illness at Raymond school event</i> June 17, 2011. Available at: http://www.jsonline.com/news/wisconsin/124110229.html Accessed on February 22, 2012.
38	April 2011 Texas	<i>Salmonella</i>	Raw milk	4 illnesses 3 children 1 hospitalized	WFAA.com <i>Raw milk under scrutiny after North Texas illnesses</i> April 201, 2011. Available at: http://www.wfaa.com/news/local/Raw-milk-under-scrutiny-after-North-Texas-illnesses-120321579.html Accessed February 22, 2012.
37	November 2010 Texas	<i>Salmonella</i>	Raw milk	4 illnesses 3 hospitalized	Dallas County DHHS press release: http://www.dallascounty.org/departments/hhs/press/documents/041911RawMilk.pdf Accessed on February 22, 2012

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	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
36	October 2010 Minnesota	<i>Campylobacter jejuni</i> & <i>Cryptosporidium parvum</i>	Raw milk Licensed raw milk dairy (farm gate)	7 illnesses	Minnesota Department of Health News Release October 28, 2010. Available at: http://www.health.state.mn.us/news/pressrel/2010/milk102810.html . Accessed on February 14, 2011
35	June 2010 Colorado	<i>Campylobacter</i> & <i>E. Coli</i> O157:H7	Raw milk Legal goat-share	30 illnesses 2 children hospitalized	The Denver Channel Longmont Dairy Ordered To Stop Distribution July 2, 2010. Available at: http://www.thedenverchannel.com/news/24123738/detail.html . Accessed on February 14, 2011
34	May 2010 Minnesota	<i>E. Coli</i> O157:H7	Raw milk Licensed raw milk dairy (farm gate)	8 illnesses (lab confirmed) 4 hospitalized (including 3 children) 26/28 environmental/animal samples matched the outbreak strain	Minnesota Department of Health News Release June 11, 2010 <i>Three more E. coli cases linked to raw milk from farm. Additional testing of environmental, animal samples find outbreak strain.</i> Available at: http://www.health.state.mn.us/news/pressrel/2010/ecoli061110.html . Accessed on February 15, 2011. MDA/MDH investigation into <i>E. coli</i> O157:H7 illnesses and Raw Milk Consumption from Hartmann Farm (June 2010). Available at: http://www.health.state.mn.us/foodsafety/alert/ecoli0610.html . Accessed on February 14, 2011. ProMED-mail. <i>E. coli</i> O157 – USA (Minnesota) unpasteurized milk. ProMED-mail 2010; 07 JUN 2010. 20100607.1900. < http://www.promedmail.org >. Accessed February 16, 2011. http://www.promedmail.org/pls/otn/f?p=2400:1202:33094:25886738639::NO::F2400_P1202_CHECK_DISPLAY_F2400_P1202_PUB_MAIL_ID:X,83:110
33	April 2010 Utah	<i>Salmonella</i> <i>Newport</i>	Raw milk Licensed raw milk dairy	10 illnesses (lab confirmed) Median age: 21 yrs old Range 2 to 56 yrs old 1 hospitalized	Utah Department of Health & Department of Agriculture and Food http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5926a6.htm . Accessed on February 14, 2011

Summary of Food Borne Illnesses & Outbreaks in North America Associated with the Consumption of Raw Milk and Raw Milk Dairy Products (2000-2011).

(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
32	April 2010 Utah	<i>Campylobacter</i>	Raw milk Licensed raw milk dairy	9 illnesses	Standard-Examiner <i>Nine sickened by campylobacter / illness linked to raw milk</i> May 17, 2010 http://www.standard.net/topics/food/2010/05/17/nine-sickened-campylobacter-illness-linked-raw-milk , Accessed on February 14, 2011
31	March 2010 Multistate; Michigan, Indiana, Illinois	<i>Campylobacter</i>	Raw milk cow share - Not inspected / regulated in Michigan Raw milk originated from Indiana	12 illnesses (lab confirmed) Range: 2 to 51 yrs old (many were children younger than 4 yrs old)	US FDA News Release March 26, 2010 http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2010/ucm206311.htm , Accessed on February 14, 2011 Michigan Department of Community Health http://www.michigan.gov/mdch/0,1607,7-132-8347-233814--00.html , Accessed on February 14, 2011
30	March 2010 Pennsylvania	<i>Campylobacter</i>	Raw milk Licensed raw milk dairy	10 illnesses 1 suffered Guillain-Barre syndrome / hospitalized	PR Newswire <i>Pennsylvania Agriculture Department Suspends Raw Milk Sales Permit of Pasture Maid Creamery in Lawrence County</i> April 8, 2010 http://www.prnewswire.com/news-releases/pennsylvania-agriculture-department-suspends-raw-milk-sales-permit-of-pasture-maid-creamery-in-lawrence-county-90216057.html , Accessed on February 14, 2011
29	February - May 2010 Washington	<i>E. Coli</i> O157:H7	Raw milk Licensed raw milk dairy	8 illnesses (1 resident from British Columbia, Canada had acquired raw milk from the dairy)	Washington State Department of Health News Release. May 27, 2010. Available at: http://www.doh.wa.gov/Publicat/2010_news/10-087.htm , Accessed on February 14, 2011
28	January 2010 New York	<i>Campylobacter</i>	Raw milk Licensed raw milk dairy (farm gate)	5 illnesses	K.MacDonald (Epidemiologist, Washington State DOH) (personal communication) New York State Department of Health http://www.health.state.ny.us/press/releases/2010/2010-01-29_campylobacter_contamination_in_raw_milk.htm , Accessed on February 14, 2011

Summary of Food Borne Illnesses & Outbreaks in North America Associated with the Consumption of Raw Milk and Raw Milk Dairy Products (2000-2011).

(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
27	December 2009 British Columbia	<i>Campylobacter</i> & <i>STEC positive</i>	Illegal cow share & distribution	1 illness (20 mo old child)	G. Embree, Fraser Health Authority (personal communication)
26	November 2009 Washington	<i>E. Coli</i> O157:H7	Raw milk Licensed raw milk dairy	3 illnesses	Washington State Department of Agriculture News Release Dec. 2, 2009 http://www.agr.wa.gov/news/2009/09-38.aspx , Accessed on February 14, 2011
25	August 2009 Wisconsin	<i>Campylobacter</i>	Raw milk Illegal cow share	35 illnesses 21 under 18 yrs old 1 hospitalized	ProMED-mail. <i>Campylobacteriosis</i> , unpasteurized milk – USA (Wisconsin). ProMED-mail 2009; 17 Sep 2009: 20090917.3264 < http://www.promedmail.org >, Accessed 14 Feb 2011. http://www.promedmail.org/pls/otn/f?p=2400:1202:33094_25886738639::NO::F2400_P1202_CHECK_DISPLAY_F2400_P1202_PUB_MAIL_ID:X,79266 Gazette Extra Officials shut down Elkhorn Farms' Raw Milk Sales Sep. 19, 2009 http://gazettextra.com/weblogs/latest-news/2009/sep/19/officials-shut-down-elkhorn-farms-raw-milk-sales/ , Accessed February 14, 2011
	June 2009	Summary US illnesses for 2006: Although the dairy commodity accounted for only 3% of single commodity outbreak-related cases (16 outbreaks and 193 cases), 71% of dairy outbreak cases were attributed to unpasteurized (raw) milk (10 outbreaks and 137 cases). A wide range of bacterial pathogens were associated with unpasteurized milk outbreaks, including <i>Campylobacter</i> (six outbreaks), <i>STEC</i> O157 (two outbreaks), <i>Salmonella</i> (one outbreak), and <i>Listeria</i> (one outbreak), resulting in 11 hospitalizations and one death.			Surveillance for Foodborne Disease Outbreaks – United States, 2006 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5822a1.htm , Accessed July 7, 2009.
24	April 2009 Colorado	<i>Campylobacter</i>	Raw milk Legal cow share	11 illnesses	Colorado Department of Public Health and Environment Cow share operation ordered to temporarily stop distribution of raw milk products April 7, 2009 http://www.cdphe.state.co.us/release/2009/040709.html , Accessed July 7, 2009.

Summary of Food Borne Illnesses & Outbreaks in North America Associated with the Consumption of Raw Milk and Raw Milk Dairy Products (2000-2011).

(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
23	March 2009	<i>Listeria monocytogenes</i>	Raw milk cheese	4 illnesses in pregnant women	The Spokesman-Review
	Washington		Unpasteurized Mexican style cheese (illegal)	1 prenatal death & 1 stillbirth occurred	Investigators search for source of <i>Listeria</i> March 7, 2009 http://www.theolympian.com/southsound/story/779784.html , Accessed on July 7, 2009
22	February 2009	<i>Campylobacter</i>	Raw milk	6 illnesses	Pennsylvania Department of Health
	Pennsylvania		License raw milk dairy (farm gate)		Consumer Advisory: Pennsylvania Health and Agriculture departments warn consumers about raw milk sold in Lawrence County February 20, 2009 http://news.pnnewswire.com/DisplayReleaseContent.aspx?ACCT=104&STORY=/www/story/02-20-2009/0004976048&EDATE= , Accessed July 7, 2009.
21	September 2008	<i>Campylobacter</i>	Raw milk	68 illnesses 25 lab confirmed illnesses Median age 29 yrs Range 5 to 61 yrs old 43 with symptoms (not lab confirmed)	Health and Agriculture departments warn consumers about raw milk sold in Montgomery County September 12, 2008 http://www.portal.state.pa.us/portal/server.pt/document/1035547/health_and_agriculture_departments_warn_consumers_about_raw_milk_sold_in_montgomery_county.pdf?cid=71994725&rank=1 , Accessed on May 25, 2011.
	Pennsylvania		Licensed raw milk dairy		September 24, 2008 update http://www.dsf.health.state.pa.us/health/lib/health/epidemiology/Raw_Milk_Update.pdf , Accessed July 7, 2009.
20	June / July 2008	<i>E. Coli</i> O157	Raw milk	14 illnesses (7 confirmed) Median age was 5 yrs (range: 1 – 81 yrs) 5 hospitalized (4 children) 4 developed HUS or thrombotic thrombocytopenic purpura	Connecticut Epidemiologist Vol. 29, No. 2 February 2009; Connecticut Department of Public Health http://www.ct.gov/dph/lib/dph/infectious_diseases/ctepinews/vol29no2.pdf , Accessed May 15, 2011
	Connecticut		Licensed raw milk dairy		http://cid.oxfordjournals.org/content/51/12/1411.abstract , Accessed July 7, 2009.

Summary of Food Borne Illnesses & Outbreaks in North America Associated with the Consumption of Raw Milk and Raw Milk Dairy Products (2000-2011).

(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
19	May/June 2008 California	<i>Campylobacter jejuni</i>	Raw milk Legal cow-share	16 illnesses (3 confirmed, 12 suspected, 1 employee) 1 hospitalized - developed Guillain-Barre syndrome	ProMED-mail. Campylobacteriosis, unpasteurized milk – USA (California). ProMED-mail 2008; 17 Aug: 20080817.2557, < http://www.promedmail.org >, Accessed 13 Mar 2009. http://www.promedmail.org/pls/qtn/?p=2400:1202:34313:14909208335::NO::F2400_P1202_CHECK_DISPLAY.F2400_P1202_PUB_MAIL_ID:X.73579 http://www.marlerclark.com/case_news/view/alexandre-ecodairy-campylobacter-outbreak-in-raw-milk/ , Accessed June 7, 2011. The Daily Triplicate Illness halts raw milk program August 16, 2008 http://www.triplicate.com/news/story.cfm?story_no=9851 , Accessed on July 7, 2009.
18	Nov./Dec 2007 California	<i>Campylobacter jejuni</i>	Raw milk and colostrum – commercially available Licensed raw milk dairy	11 illnesses (8 confirmed; 3 suspect)	State of California – Health and Human Services Agency, California Department of Public Health CA EPI 08-03: Cluster of <i>Campylobacter</i> infections possibly associated with raw dairy products http://www.marlerblog.com/Cluster%20of%20Campylobacter%20infections.pdf , Accessed July 7, 2009.
17	Oct./Nov. 2007 Kansas	<i>Campylobacter jejuni</i>	Unpasteurized fresh cheese served at small local community celebration milk was purchased from licensed raw milk dairy, but was made into unpasteurized fresh cheese by purchaser	68 illnesses; Median age was 25 (range: 1 – 75 yrs) 2 hospitalized	MMWR. January 2, 2009 / 57(51 & 52): 1377-1379 http://www.cdc.gov/mmwr/PDF/wk/mm5751.pdf , Accessed July 7, 2009.
16	Aug – Dec. 2007 Kansas	<i>Campylobacter jejuni</i>	Raw milk Farm gate sales permitted	25 illnesses	Kansas Department of Health & Environment http://www.kdheks.gov/epi/download/BU_RN_Campy_Nov07_final_report.pdf , Accessed July 7, 2009.

Summary of Food Borne Illnesses & Outbreaks in North America Associated with the Consumption of Raw Milk and Raw Milk Dairy Products (2000-2011).

(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
15	March 2007 Utah	<i>Campylobacter jejuni</i>	Raw milk	15 illnesses; 1 hospitalized	ProMED-mail: Campylobacteriosis, unpasteurized milk – USA (Utah). ProMED-mail 2007: 22 Aug. 20070322.1004, < http://www.promedmail.org >, Accessed 13 Mar 2009.
14	March 2007 Ontario, Canada	<i>Yersinia</i>	Suspect raw milk from family farm	1 illness (2 yr old child)	Grey Bruce Health Unit Public Release, March 16, 2007 http://www.publichealthgreybruce.on.ca/home/NewsEvents/2007/Mar/2007Mar16_Yersinia-Infection.htm , Accessed July 7, 2009.
13	March 2007 Ontario, Canada	<i>Listeria monocytogenes</i>	Suspect raw milk cheese	1 illness (newborn); suspect maternal transfer to newborn	Grey Bruce Health Unit Public Release, March 14, 2007 http://www.publichealthgreybruce.on.ca/home/NewsEvents/2007/Mar/2006Mar14_Infant-Listeriosis.htm , Accessed July 7, 2009.
12	Feb - July 2007 Pennsylvania	<i>Salmonella typhimurium</i>	Licensed raw milk dairy Raw milk & raw milk queso fresco cheese	29 illnesses (3 clusters); Median age was 6 yrs (range: 5 months – 76 yrs);	MMWR Weekly November 9, 2007 / 56(44):1161-1164 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5644a3.htm , Accessed July 7, 2009.
11	Sept. 2006 California	<i>E. Coli</i> O157:H7	Licensed raw milk producer; Raw milk and/or colostrum	6 illnesses (children); Median age was 8 (range: 6 – 18 yrs); 3 hospitalized	MMWR Weekly June 13, 2008 / 57(23):625-628 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5723a2.htm , Accessed July 7, 2009.
10	Sept. 2006 Washington	<i>E. Coli</i> O157:H7	Licensed raw milk producer Raw milk	2 illnesses (children) 1 hospitalized	Washington State Department of Health – News Release http://www.doh.wa.gov/Publicat/2006_news/06-154.htm , Accessed July 7, 2009.
9	May/June 2006 Wisconsin	<i>Campylobacter jejuni</i>	Illegal production / distribution; (Note: unpasteurized dairy products not permitted in Wisconsin); Unpasteurized cheese curds	>40 illnesses;	State of Wisconsin Department of Health and Family Services – News Release http://dhs.wisconsin.gov/news/PressReleases/2006/062006cheesecurdoutbreak.pdf , Accessed on July 7, 2009.
8	Feb. 2006 North Carolina	<i>Listeria monocytogenes</i>	Unpasteurized Mexican soft cheese	1 premature baby; infected by maternal transfer during delivery	Mecklenburg County Health Department http://charmeck.org/mecklenburg/county/NewsArchives/2006Stories/February/Pages/listeria022206.aspx , Accessed May 25, 2011

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(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
7	Jan. 2006 Colorado	<i>Campylobacter jejuni</i>	Raw milk Sale of raw milk is illegal in CO, but Cow-Share programs are permitted.	5 illnesses (range: 7 - 44 yrs)	Colorado Department of Public Health and Environment (CDPHE) http://www.apha.org/membergroups/newsletters/section/newsletters/epidem/winter06/2454.htm , Accessed July 7, 2009.
6	Nov. / Dec. 2005 Washington	<i>E. Coli</i> O157:H7	(Dee Creek Farm); Unlicensed farm; Cow Share Program	18 illnesses; Washington & Oregon; Median age was 9 yrs (range: 1 - 47 yrs) 15 children; 5 hospitalizations; 4 developed HUS.	MMWR Weekly March 2, 2007 / 56(08):165-167 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5608a3.htm , Accessed July 7, 2009.
5	2003 Utah	<i>Campylobacter jejuni</i>	Raw milk served at high school athletic dinner	13 illnesses (range: 11 - 50 yrs)	Peterson, MC. 2003. J Environ Health. May 2003; 65(9):20-21. Accessed July 7, 2009.
4	Nov. 2002 - Feb. 2003 Multistate: Illinois, Indiana, Ohio, and Tennessee	<i>Salmonella typhimurium</i>	At the time, this was the only dairy in Ohio legally permitted to distribute raw milk and raw milk products; At present, no raw milk dairies are permitted in Ohio Raw milk and raw milk products served at dairy and on farm restaurant	62 illnesses; Median age was 18 yrs (range: 1 - 70 yrs)	MMRW Weekly July 4, 2009 / 52(26); 613-615 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5226a3.htm , Accessed July 7, 2009.
3	Nov. / Dec. 2001 Wisconsin	<i>Campylobacter jejuni</i>	Cow Share Program; Raw milk	75 illnesses; Median age was 30 yrs (range: 2 - 63 yrs)	MMRW Weekly June 28, 2002 / 51(25); 548-549 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5125a2.htm , Accessed July 7, 2009.
2	Aug. 2001 Vancouver Island, British Columbia	<i>E. Coli</i> O157:H7	Cooperative farm; Raw goat's milk	5 illnesses (children); 2 hospitalizations for HUS;	CCDR Vol. 28-01 1 January 2002 http://www.phacaspc.gc.ca/publicat/ccdrmtc/02vol28/dr2801eb.html , Accessed July 7, 2009.

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(Note: This table does not include raw milk cheeses that are aged >60 days)

	Date	Pathogen	Implicated Source(s)	Outbreak Information	Reference
1	Oct. 2000 – Jan. 2001 North Carolina	<i>Listeria monocytogenes</i>	Unpasteurized Mexican soft cheese, raw milk	12 illnesses; Median age was 21 yrs (range: 18 – 38 yrs); 10 pregnant women (5 stillbirths; 3 premature deliveries; 2 infected newborns)	MMWR Weekly July 6, 2001 / 50(26): 560-562 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5026a3.htm , Accessed July 7, 2009.

Other sources or links that discuss outbreaks or recalls associated with raw milk / raw milk products:

bites: <http://bites.ksu.edu/rawmilk>

Kansas State University: <http://www.foodsafety.ksu.edu/articles/384/RawMilkOutbreakTable.pdf>

Cornell University: <http://www.milkfacts.info/Milk%20Microbiology/Disease%20Outbreaks.htm>

Real Raw Milk Facts: <http://www.realrawmilkfacts.com/PDFs/1998-2011-outbreaks-raw-dairy.pdf>

APPENDIX 4

BC Raw Milk Outbreaks and Illnesses

Month / Year	Number Ill	Age (if known)	Agent of Illness	Source of Milk	Other details of investigation
Feb 2010; May 2010	6 2		<i>E.coli</i> O26 and/or <i>E.coli</i> O157:H7 STEC	Licensed raw milk dairy in Washington state. Whatcom County, WA. Jackies Jersey Milk	Both outbreaks involved one or more BC residents. Milk tested positive for <i>E.coli</i> O26 in Feb 2010, and shortly after illnesses reported. Source: K. MacDonald (Epidemiologist, WA) http://www.doh.wa.gov/Publicat/2010_news/10-087.htm
Dec 2009	1	20 month old	<i>Campylobacter</i> and STEC positive	Home on the Range Farms, BC. Purchased from Anita's Pharmacy in Burnaby	Child lived in Port Coquitlam. No milk from family was leftover so testing could not be conducted. Source: G. Embree (Fraser Health)
Aug 2001	5	1, 2, and 7 yrs old	<i>E.coli</i> O157	Cooperative farm, goat's milk, near Nanaimo, BC	Source: http://www.collectionscanada.gc.ca/webarchives/20071122092132/http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/02vol28/index.html L. McIntyre (BCCDC)

Source: Food Protection, Environmental Health Services, BC Centre for Disease Control

Food and Drug Regulations

“stored” means to have been kept or held at a temperature of 2°C or more for a period of 60 days or more from the date of the beginning of the manufacturing process;

B.08.044. (1) Subject to subsection (2), no person shall sell cheese, including cheese curd, that is not made from a pasteurized source unless it has been stored.

In addition, the cheese must meet certain microbiological criteria in the finished product

B.08.048. (1) Subject to section B.08.054, no person shall sell cheese, including cheese curd, made from a pasteurized source if the cheese contains more than

- (a) 100 *Escherichia coli*, or
 - (b) 100 *Staphylococcus aureus*
- per gram, as determined by official method MFO-14, Microbiological Examination of Cheese, November 30, 1983.

(2) No person shall sell cheese, made from an unpasteurized source if the cheese contains more than

- (a) 500 *Escherichia coli*, or
 - (b) 1,000 *Staphylococcus aureus*
- per gram, as determined by official method MFO-14, Microbiological Examination of Cheese, November 30, 1983.

APPENDIX 2

Raw Milk Contaminants and Pathogens

Key: O – known outbreaks (P-pasteurized milk only)
H – historical importance
R – rare disease occurrence
T – theoretical disease transmission
Z/H – zoonotic or human disease transmission

List of agents known or theoretically possible
in raw milk. Agents listed alphabetically.

Category – B bacterial; C chemical; P parasites; V viral.

Agent	Cat	Disease	O	H	R/T	Z/H	Refs
Arsenic	C	Arsenic	✓ (P)		R		[1]
<i>Brucella abortus</i> <i>B. melitensis</i> <i>B. suis</i> <i>B. canis</i>	B	Brucellosis	✓	✓		Z	[2, 3]
<i>Campylobacter jejuni</i> <i>Campylobacter coli</i>	B	Campylobacteriosis Guillain-Barré syndrome	✓			Z	[4-9]
<i>Corynebacterium diphtheriae</i>	B	Diphtheria	✓	✓		H	[3, 10]
<i>Corynebacterium pseudotuberculosis</i>	B				R		[3]
<i>Coxiella burnetti</i>	B	Q-Fever		✓	R	Z	[1, 11]
<i>Cryptosporidium parvum</i> <i>Cryptosporidium andersoni</i>	P	Cryptosporidiosis	✓		R	Z	[12]
<i>Escherichia coli</i> 0157:H7 <i>E.coli</i> verotoxigenic	B	EHEC – enterohaemorrhagic <i>E.coli</i> HUS – haemolytic uremic syndrome	✓			Z	[13-18]
Hepatitis A	V	Jaundice (infectious hepatitis)	✓		R	H	[1]
Histamine	C	Histamine intoxication	✓				[1]
Iron	C	Iron intoxication			R		[1]
<i>Ixodes persulcatus</i> <i>Ixodes ricinus</i>	P	Tickborne encephalitis			T	Z	[19-21]
<i>Listeria monocytogenes</i>	B	Listeriosis	✓			Z	[22-25]
<i>Lyssavirus</i> (Rhabdovirus family)	V	Rabies			T		[26-28]
<i>Mycobacterium bovis</i> <i>Mycobacterium tuberculosis</i>	B	Tuberculosis	✓	✓		Z	[1, 3, 23, 29]
Poliovirus types 1, 2, 3 (genus <i>Enterovirus</i>)	V	Poliomyelitis		✓	R	H	[1]
<i>Pseudomonas aeruginosa</i>	B	<i>Pseudomonas</i> enteritis	✓ (P)	✓	R		[1]
<i>Salmonella enterica</i> subsp. <i>enterica</i> serovar Typhi or <i>S. Typhi</i>	B	Typhoid Fever	✓			H	[1, 10, 30- 35]
<i>S. Paratyphi</i> A <i>S. Paratyphi</i> B	B	Paratyphoid Fever	✓		R	H	[10]
<i>Salmonella</i> spp.	B	Salmonellosis	✓			Z	[25, 30-37]
<i>Shigella dysenteriae</i> , <i>S.</i> <i>flexneri</i> , <i>S. sonnei</i>	B	Shigellosis	✓	✓		H	[38]

Agent	Cat	Disease	O	H	R/T	Z/H	Refs
<i>Staphylococcus aureus</i> – antibiotic resistant strains	B	MRSA			T*	H	
<i>Staphylococcus aureus</i> enterotoxins	B	Staphylococcal intoxication	✓	✓		H	[39]
<i>Streptobacillus moniliformis</i>	B	Haverhill fever (Rat-bite fever)	✓	✓	R	Z	[1, 3]
<i>Streptococci pyogenes</i> (Group A)	B	Scarlet Fever	✓	✓		H	[1, 10]
<i>Streptococci pyogenes</i> (Group A)	B	Septic Sore Throat	✓	✓		H	[1, 10]
<i>Toxoplasma gondii</i>	P	Toxoplasmosis			R	Z	[1, 23]
Tremetol	C	Milk Sickness		✓		Z	[1]
Unknown		Brainerd diarrhea syndrome			R		[40]
<i>Yersinia enterocolitica</i>	B	Yersiniosis	✓			Z	[3, 23, 41-43]

Diseases caused by Raw Milk

References for this section are:

- i) Diagnosis and Management of Foodborne Illnesses: A Primer for Physicians and Other Health Care Professionals. Feb, 2004.
- ii) [44]
- iii) As noted.

Arsenic, Iron

(http://en.wikipedia.org/wiki/Arsenic_poisoning)

Symptoms: - vomiting
- colic
- diarrhea
- lethargy
- hyperactivity
- chest pain
- headache
- stomach pains

Incubation: few hours

Duration: variable (few days to chronic)

Infections and - long-term physical/mental complaints

Complications: - neurological damage
- kidney damage (eosinophilia)
- cardiovascular effects
- reproductive toxicity

Fatality Rate:

Brainerd Diarrhea (unknown)

Symptoms: - diarrhea, watery (acute onset)
- urgency

Incubation:

Duration: long – 2 to 36 months (median 16.5 months)

Infections and - no response to antibiotics
Complications: -
Fatality Rate:

Brucellosis (*Brucella* spp.)

Symptoms: - fever acute or insidious with continued intermittent or irregular fever of variable duration
- headache
- weakness
- profuse sweating
- chills
- arthralgia
- weight loss
- generalized aching
- depression
- bloody stools during acute phase
Incubation: 5 to 60 days
Duration: days, months up to a year
Infections and - suppurative (pus forming) infections of liver, spleen
Complications: - chronic localized infections
- chronic joint pain in 20-60% of patients (osteoarticular complications, e.g., sacroiliitis)
- genitourinary in 2 to 20% (e.g., orchitis, epididymitis)
- endocarditis
Fatality Rate: <2%

Campylobacteriosis (*Campylobacter* spp.)

Symptoms: - diarrhea (frequently with bloody stools)
- abdominal pain
- malaise
- fever
- nausea
- vomiting
Incubation: 2 to 10 days
Duration: one week, occasional prolonged illness, relapses in adults
Infections and - typhoid-like syndrome
Complications: - meningeal syndrome
- febrile convulsions
- Guillain-Barré syndrome
Fatality Rate:

Cryptosporidiosis (*Cryptosporidium* spp.)

Symptoms: - diarrhea, profuse and watery. In children anorexia & vomiting prior to diarrheal onset
- cramping abdominal pain
- general malaise
- fever
- anorexia
- nausea
- vomiting
Incubation: 1 to 12 days (average 7 days)
Duration: weeks to months for immunocompetent
Infections and - immunodeficient (especially HIV) prolonged, fulminant disease
Complications: - cholecystitis in biliary tract infections
- symptoms wax and wane (remit and relapse weeks to months)
Fatality Rate: can be significant in immunodeficient

Diphtheria (*Corynebacterium diphtheriae*)

- Symptoms: - moderate to severe sore throat (involves tonsils, larynx, nose, membranes)
 - tender enlarged lymph nodes
 - swelling and oedema of neck; airway obstruction
- Incubation: 2 to 5 days
- Duration: (?) ~2 weeks, communicable for up to 4 weeks
- Infections and - chronic nasal discharge
- Complications: - myocarditis (from toxin) leading to heart block and progressive congestive failure in ~ 1 week
 - lesions (excoriations)
 - neuropathies (mimic Guillain-Barré)
- Fatality Rate: 5 to 10% of noncutaneous diphtheria

Enterohaemorrhagic E.coli Infections (*E.coli* 0157:H7)

- Symptoms: - diarrhea (severe, bloody to mild)
 - abdominal pain
 - vomiting
 - absence of fever
- Incubation: 1 to 10 days, median 3 to 4 days
- Duration: 5 to 10 days, up to 3 weeks in children
- Infections and - Hemolytic uraemic syndrome (HUS), 8% of people progress to this syndrome
- Complications:
- Fatality Rate:

Guillain-Barré Syndrome

[Ref: http://en.wikipedia.org/wiki/Guillain-Barr%C3%A9_syndrome]

Acute inflammatory demyelinating polyneuropathy; an autoimmune disease affecting the peripheral nervous system, usually triggered by an acute infectious process.

Causes ascending paralysis, weakness in the legs spreading to upper limbs and the face along with complete loss of deep tendon reflexes.

Haverhill Fever (*Streptobacillus moniliformis*)

- Symptoms: - chills
 - fever
 - headache
 - muscle pain
 - maculopapular rash on extremities
 - swollen joints
- Incubation: 3 to 10 days
- Duration: relapses common
- Infections and - Untreated cases may result in the following:
- Complications: - bacterial endocarditis
 - pericarditis
 - parotitis
 - tenosynovitis
 - focal abscesses of soft tissues or brain
- Fatality Rate: 7 to 10% in untreated cases

Hemolytic Uraemic Syndrome

[Ref http://en.wikipedia.org/wiki/Hemolytic-uremic_syndrome]

A disease characterized by hemolytic anemia, acute renal failure (uremia) and a low platelet count (thrombocytopenia).

Histamine

Symptoms:

- headache
- nausea
- vomiting
- facial flushing
- burning throat
- thirst
- swelling of lips
- urticaria
- sweating
- palpitations
- dizziness
- rash

Incubation: minutes to a few hours

Duration: 12 hours, symptoms resolve spontaneously

Infections and - hypertension

Complications: - cerebrovascular accidents

Fatality Rate:

Note: Histamine is found in cheese, and is formed when histidine is decarboxylated to histamine. Many *Enterobacteriaceae*, enterococci, and *Lactobacillus casei* produce the enzyme, decarboxylase.

Jaundice (Infectious Hepatitis)

Symptoms:

- fever
- malaise
- anorexia
- nausea
- abdominal discomfort
- jaundice

Incubation: 15 to 50 days (average 28 to 30 days)

Duration: mild (1 to 2 weeks), severe (several months)

Infections and - prolonged, relapsing hepatitis for up to one year (15% of cases)

Complications: - chronic infection may occur

Fatality Rate: 0.1% to 0.3%; 1.8% in adults over 50.

Listeriosis (*Listeria monocytogenes*)

Symptoms:

- fever
- intense headache
- nausea
- vomiting

Incubation: 3 to 70 days (median 3 weeks)

Duration: variable

Infections and - meningoencephalitis &/or septicemia in new-borns and adults

Complications: - fever and abortion in pregnant women

- delirium, coma; occasionally collapse and shock

Fatality Rate: 30% in newborns and approaches 50% when onset occurs in the first 4 days. Higher in the elderly.

Milk Sickness (Tremetol)

Symptoms: - weakness
 - prostration
 - loss of appetite
 abdominal pain
 - nausea
 - vomiting
 - muscular tremors
 - coma

Incubation:

Duration:

Infections and -

Complications: -

Fatality Rate: frequent

Note: grazing animals eliminate trematol (a higher alcohol which is toxic to the liver) as a result of eating leaves and stems of white snakeroot (*Eupatorium rugosum*) or rayless goldenrod *Aplopappus heterophyllus* or *Isocoma wrightii*.

Poliomyelitis (Enterovirus)

Symptoms: - 'minor' in 10% of cases.
 - fever
 - malaise
 - headache
 - nausea
 - vomiting
 - 'major' illness, also includes following symptoms:
 - sever muscle pain
 - stiffness of muscle and back
 - flaccid paralysis (asymmetric)

Incubation: 7 to 14 days (range 3 to 35 days)

Duration: infectivity in stool is up to 3 weeks

Infections and - acute onset of flaccid paralysis occurs in 1% of cases

Complications: - aseptic meningitis occurs in 1% of cases
 - paralysis present after 60 days likely to be permanent
 - "postpolio syndrome", recurrence of paralysis years after infection

Fatality Rate:

Special note: This is a preventable disease through vaccination. At risk groups would be those refusing vaccination exposed to drinking raw milk that becomes contaminated by handling with persons with the infection (fecal transmission to milk).

Pseudomonas enteritis (*Pseudomonas aeruginosa*)

Symptoms: - vomiting
 - diarrhea

Incubation:

Duration:

Infections and - all outbreaks involved infants

Complications: -

Fatality Rate:

Q-fever (*Coxiella burnetti*)

- Symptoms: - chills
 - headache
 - weakness
 - malaise
 - severe sweats
- Incubation: 2 to 3 weeks
- Duration:
- Infections and - chronic Q-fever results in endocarditis, may present up to 2 yrs after initial infection
- Complications: - post Q-fever fatigue syndrome
- Fatality Rate: acute, untreated <1% to 2.4%

Septic Sore Throat (*Streptococci pyrogenes*)

- Symptoms: - fever (sudden onset)
 - exudative tonsillitis or pharyngitis (sore throat)
 - tender lymph nodes
- Incubation: 1 to 3 days
- Duration: untreated communicability is 10 to 21 days (can be treated with penicillin),
 but may be carried for several months
- Infections and - otitis media
- Complications: - peritonsillar abscess
 - acute glomerular nephritis (onset 1 to 5 weeks, mean 10 days)
 - acute rheumatic fever (onset mean 19 days)
 - rheumatic heart (valvular) disease may occur days to weeks after infection
 - Sydenham chorea may occur several months after infection
- Fatality Rate:

Scarlet Fever (*Streptococci pyrogenes*)

- Symptoms: - all symptoms associated with septic sore throat, plus;
 - skin rash (from production of pyrogenic exotoxin)
 - enanthem, strawberry tongue, exanthema
 - fever rash not on face (typically), but there is flushing of cheeks and circumoral pallor
- Incubation: 1 to 3 days
- Duration: untreated communicability 10 to 21 days (can be treated with penicillin)
- Infections and - severe infections have high fever, nausea and vomiting
- Complications: - desquamation of the skin at tips of fingers and toes
- Fatality Rate: as high as 3%

Salmonellosis (*Salmonella* spp.)

- Symptoms: - acute enterocolitis
 - headache
 - fever
 - abdominal pain
 - diarrhea
 - nausea
 - vomiting
 - dehydration (severe in children and the elderly)
- Incubation: 6 to 72 hours, usually 12 to 26 hours
- Duration: 4 to 7 days (sometimes weeks)

Salmonellosis (*Salmonella* spp.) – continued:

Infections and - septicemia

Complications: - focal infection

- abscesses
- septic arthritis
- cholecystitis
- endocarditis
- meningitis
- pericarditis
- pneumonia
- pyoderma
- pyelonephritis

Fatality Rate: rare

Typhoid and Paratyphoid Fever (*S. Typhi*, *S. Paratyphi*)

Symptoms: - fever
- headache
- malaise
- anorexia
- bradycardia
- splenomegaly
- cough
- rose spots on trunk
- constipation

Incubation: Typhoid: 3 to 60 days, usually 8-14 days; Paratyphoid: 1 to 10 days

Duration: 4 to 7 days

Infections and - mild illness is gastroenteritis (see Salmonellosis)

Complications: - severe illness becomes systemic with potential for following symptoms;
- non-sweating fevers, mental dullness, slight deafness, parotitis
- peyer patches in ileum can ulcerate, intestinal hemorrhage in 1%
- 15 to 20% may experience relapses

Fatality Rate: without antibiotics, 10 to 20%; with antibiotics <1%

Special Note: 2 to 5% become permanent carriers (exclude from food handling)

Shigellosis (*Shigella* spp.)

Symptoms: - diarrhea (with blood and mucus)
- fever
- nausea
- toxemia
- cramps
- tenesmus

Incubation: 12 to 96 hours, usually 1 to 3 days

Duration: 4 to 7 days

Infections and - convulsions in young children

Complications: - *S. dysenteriae* type 1: toxic megacolon, intestinal perforation
- *S. dysenteriae* type 1HUS
- *S. flexneri*: reactive arthropathy (Reiter syndrome)

Fatality Rate: *S. dysenteriae* type 1 – up to 20%

Staphylococcal intoxication (*Staphylococcus aureus*)

- Symptoms: - vomiting
 - nausea
 - cramps
 - prostration
 - diarrhea
- Incubation: 30 minutes up to 8 hours (usually 2 to 4 hours)
- Duration: 24 to 48 hours
- Infections and - abrupt and violent onset of vomiting, may require hospitalization
- Complications: -
- Fatality Rate: rare

MRSA (Methicillin resistant *Staphylococcus aureus*)

- Symptoms: - skin lesions
 - fever
 - malaise
 - headache
 - anorexia
- Incubation: variable
- Duration: -
- Infections and - pneumonia
- Complications: - lung abscess
 - osteomyelitis
 - sepsis
 - endocarditis
 - arthritis
 - meningitis
 - toxic shock syndrome
- Fatality Rate: -

Tickborne encephalitis (*Ixodes* spp.)

- Symptoms: - focal epilepsy
 - flaccid paralysis
 - fever
- Incubation: 7 to 14 days
- Duration: 3 weeks
- Infections and - fever and meningoencephalitis follow 4 to 10 days after apparent recovery
- Complications: - death and severe residua may occur
- Fatality Rate: up to 10% with Powassan encephalitis (PE)
- Note: Ticks (*Ixodes* spp.) carry flaviviruses that cause the infection. CEE or Central European tick-borne encephalitis is also known as diphasic milk fever or diphasic meningoencephalitis. Powassan virus is present in Canada. Tick biting season peaks in Canada from June to September.

Toxoplasmosis (*Toxoplasma gondii*)

- Symptoms: - swollen/enlarged lymph nodes
 - fever
 - lymphocytosis (increase in lymphocyte counts in blood)
- Incubation: 5 to 23 days
- Duration: months
- Infections and - immunodeficient (especially HIV) other symptoms;
- Complications: - maculopapular rash
 - generalized skeletal muscle involvement
 - cerebritis
 - chorioretinitis
 - pneumonia
 - myocarditis
 - cerebral toxoplasmosis
 - death
 - infection during early pregnancy causing fetal infection;
 - death of fetus
 - chorioretinitis
 - brain damage
 - hydrocephaly
 - microcephaly
 - fever
 - jaundice
 - rash
 - hepatosplenomegaly
 - xanthochromic CSF
 - convulsions at birth or afterwards
- Fatality Rate: significant in immunodeficient individuals and early fetal infections

Tuberculosis (bovine) (*Mycobacterium bovis*)

- Symptoms: - lung lesions (pulmonary)
 - lesions in other organs (extrapulmonary): lymph nodes, pleura, pericardium, joints etc.
- Incubation: 2 to 10 weeks
- Duration: years
- Infections and - 10% of those initially infected will develop active infection
- Complications: - HIV+ more at risk
 - drug resistance problematic
- Fatality Rate: - significant, 65% of those infected will die within 5 years (if untreated)

Yersiniosis (*Yersinia enterocolitica*)

- Symptoms: - fever
 - diarrhea
 - abdominal pain (especially in children)
 - acute mesenteric lymphadenitis (mimics appendicitis)
- Incubation: 24 hrs to 7 days (usually <10 days)
- Duration: 1 to 3 weeks
- Infections and - systemic infections
- Complications: - reactive arthritis
 - Reiter syndrome
 - erythema nodosum (red nodules on the skin -- inflammation of subcutaneous fat)
 - septicemia
- Fatality Rate:

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #: 928367 xref 908529

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

TITLE: Overview of the Outcome of the BC Abattoir Inspection Review

PURPOSE:

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BACKGROUND:

In the spring of 2010, government requested a review of the meat inspection system for provincially licensed Class A and B slaughter plants to identify potential modifications and alternatives. In response, the Ministry of Health (MoH) established a steering committee to lead the BC Abattoir Inspection System Review (BCAISR). Government directed that a new system will need to effectively ensure meat safety, livestock health and welfare, support the BC meat industry and be sustainable.

In the fall of 2010, the Canadian Food Inspection Agency (CFIA), which currently provides inspection services in BC, announced it would cease to provide inspection services in provincial plants on January 1, 2014. Three provinces including BC are affected by this decision. This announcement focused the review on identifying options for a new provincial inspection system. The review included research and consultations with stakeholders and meat inspection experts.

A report was developed to present the findings of the review that lays out nine recommendations for a future provincial meat inspection system, two potential system designs and advice for implementation. The report does not contain financial costing information.

DISCUSSION:

s. 13

s. 13

FINANCIAL IMPLICATIONS:

S. 13

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Date: May 14, 2012

File Name with Path: I:\Health Protection\Protection\BRIEFING NOTES\2012\928367 Meeting with BC Cattleman's Association May 16\928367 - 908529 Joint minister briefing on BCAISR.docx

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 920663

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

TITLE: Informed Dining Program – Promotional Campaign

PURPOSE: To seek direction on the preferred approach for the promotional campaign for the Informed Dining program, highlighting the first group of restaurants that have signed up.

BACKGROUND:

The Informed Dining program requires participating restaurants to provide nutrition information for all standard menu items (e.g. anything on the menu for more than 60 days) before or at the point of ordering. This information consists of calories and 13 core nutrients and is to be displayed on a menu insert, brochure or poster.

The Canadian Restaurant and Foodservices Association (CRFA), the BC Restaurant and Foodservices Association (BCRFA) and the Heart and Stroke Foundation of Canada provided valuable advice to Ministry of Health staff in the development of the program. While voluntary for restaurants in British Columbia, the Informed Dining program will be mandated for retail food service establishments in health care facilities with implementation anticipated for 2012/2013.

The program is being promoted to BC restaurants by the CRFA and BCRFA, and HealthLinkBC Registered Dietitians are providing essential advice and services to the smaller restaurants to facilitate program adoption. Environmental Health Officers are recruiting restaurants by raising awareness and educating restaurant operators as part of their routine food safety inspections.

Since last fall, the program was promoted at the Sysco Food Expo in Langley, the BC Hospitality Expo in Vancouver, the BC Food Expo in Vancouver and at Dine Around Victoria. To date 33 restaurants have signed Letters of Agreement and 61 restaurants have submitted Expressions of Interest. This includes national chains, BC chains and small independent restaurants. See Appendix 1 for a full list.

DISCUSSION:

Promoting the Informed Dining program presents an opportunity to showcase the participants and partners of the program, and to invite consumers to request nutrition information when dining out. The Minister of Health made a commitment to the industry to provide significant promotional opportunities if they voluntarily participated in the program; this message was reiterated in a November 2011 letter.

Many of the restaurants want to participate in response to consumer demand for nutrition information and are attracted to the incentives offered to all participants. For restaurants that committed to participate before January 31, 2012, there was an incentive of province-wide promotional opportunities in May 2012, which could include:

- a two-week Global TV run of vignettes, featuring TV personality and Registered Dietitian Melodie Yong, with food service industry representatives and early adopters of the program;
- six segments featuring different restaurant sectors: upscale full service restaurants (e.g. Boathouse), family style/full service restaurants (e.g. De Dutch), small, independent restaurants (e.g. Swiftsure; The Reef), national and provincial quick-service chains (e.g. Little Caesars Pizza, A&W);
- a two-page advertorial spread in major daily newspapers, including the Vancouver Sun, The Province, the Globe and Mail (BC edition), the Times Colonist and other key regional dailies;
- out-of-home advertising, e.g. transit shelters and bus backs, with creative approved by the food service industry; and
- online social media, including Facebook, Twitter and the Healthy Families BC (HFBC) blog, with a call to action via an Informed Dining contest (details to be developed).

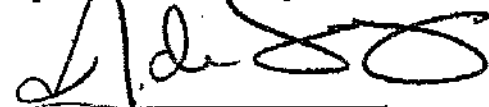
S. 17

FINANCIAL IMPLICATIONS:

S. 13, S. 17

RECOMMENDATION:

Option 1 -- Full scale promotion



Approved Not Approved
Michael de Jong, QC
Minister of Health

MAR 21 2012

Date Signed

Program ADM/Division: Arlene Paton, Population and Public Health

Telephone: 952-1731

Program Contact (for content): Silas Brownsey

Drafter:

Date: February 29, 2012

File Name with Path: I:\ACTNOW_BC\BRIEFING NOTES 280-20\BRIEFING NOTES\2012\920663 INFORMED DINING PROMOTIONAL OPTIONS.DOCX

Appendix 1
Signed Legal Agreements for Informed Dining Program
(as of February 2, 2012)

Courtenay

- Union Street Grill & Grotto

Cranbrook

- Heidi's Restaurant

Hazelton

- The Historic BC Cafe

Kelowna

- Ricardo's Mediterranean Kitchen

Nanaimo

- New York Style Pizza & Pasta

Nelson

- El Taco

Penticton

- Pasta Factory

Revelstoke

- Bad Paul's Roadhouse Grill

Smithers

- Capri Family Restaurant
- Baristas Best Coffee
- Mountain Eagle Books
- Riverhouse Restaurant
- Twin Valley Restaurant

Vancouver

- Aphrodite's Organic Cafe and Pie Shop
- Boathouse (7)
- Bridges Restaurant, Bistro & Bar
- Burgoon Bistro (4)
- El Taco
- H.A.V.E
- Hubub Sandwiches Inc.
- Thai Away Restaurants Ltd.

Victoria

- Joseph's Coffee House
- Six Mile Pub
- Smuggler's Cove Pub
- Strathcona Group (5)
- Swiftsure Restaurant and Lounge

- The Reef

White Rock

- El Taco

Province-wide Franchises:

- De Dutch - 18 outlets
- Little Caesars Pizza - 44 outlets
- A&W - 175 outlets

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 921216

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

TITLE: Traces of Listeria Found in Vancouver Ready-to-eat Fish Products –
Media Advisory February 27, 2012

PURPOSE: To alert the Minister of Health of the February 27, 2012 Media Advisory

BACKGROUND:

A Media Advisory was released on February 27, 2012 titled *Traces of Listeria found in Vancouver*. A University of British Columbia (UBC) study found traces of the bacteria *Listeria monocytogenes* (commonly called Listeria) in ready-to-eat (RTE) fish products sold in Metro Vancouver. UBC tested a total of 80 samples of RTE meat and fish products prior to their best before date. The findings published in a recent issue of the journal *Food Microbiology* reports Listeria was present in 20 per cent (8 samples) of the 40 RTE fish product samples tested. In 5 per cent of the samples (2 of 40) Listeria was observed. However, the levels in all the tested RTE fish products were below federal guidelines. *Listeria monocytogenes* can make individuals sick and is potentially lethal for at risk groups.

Researchers also tested RTE meat products from the same Metro Vancouver retailers where they bought and tested the fish products. However, they did not find Listeria in any of the 40 meat samples which included bologna, corned beef, cooked ham and pepperoni.

DISCUSSION:

Listeria is a type of bacterium often found in food. *Listeria monocytogenes* can cause a rare but serious disease called listeriosis, especially among at risk groups (e.g. pregnant women, children, the elderly or individuals with a weakened immune system). A 2008 outbreak of listeriosis, traced to deli meats from Maple Leaf Foods, resulted in 5 confirmed BC cases, two of whom died, with a total of 22 deaths across Canada. RTE foods have food chemistry environments (e.g. wet, cool, salty, and/or sugary) in which the bacteria can thrive and potentially multiply even when refrigerated. Moreover, foods contaminated with Listeria often look, smell and taste normal.

SUMMARY ADVICE:

A media release has raised the profile of the presence of Listeria in RTE foods in BC. Although Listeria was present in 20 per cent of the 40 samples of RTE fish products (2 of 40), the levels were below federal guidelines and were considered safe for human consumption. Vulnerable individuals should exercise caution in consumption of potentially risky foods, like ready to eat fish products. Education has been directed to at risk populations to assist them to make safer choices. BC Center of Disease Control released a report entitled *Occurrence and distribution of Listeria species in facilities producing ready-to-eat foods under provincial inspection authority in BC* (December 2010) that included recommendations to minimize Listeria in RTE foods. Progress has been occurring on these recommendations (see attached for more information).

Program ADM/Division: Arlene Paton, ADM, Population and Public Health.
Telephone: 250 952-1731
Program Contact: Lorie Hryciuk, Director, Director of Food Protection
Drafter: Carrie Landry, Food Protection and Policy Specialist
Date: February 29, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\921216 - Traces of Listeria in
Vancouver RTE Fish Products Media Adv Feb 27.docx

Appendix A: Summary Status of Recommendations

All recommendations from the 2010 BC Center for Disease Control ¹ report are completed or in progress.

RECOMMENDATION	RESPONSIBILITY	STATUS
1) EDUCATING THE PUBLIC Reminding vulnerable populations in BC of the risk associated with the consumption of food products such as soft cheeses, deli-meats and smoked fish. This advice should be set in the context of the relatively low level of reported listeriosis in BC (a median of 11 cases per year from 2000-2009), despite the high level of morbidity and mortality associated with those severe listeriosis infections which do occur. In particular, until levels of <i>L. monocytogenes</i> in BC product drop, or until a province wide testing and labeling program can be put in place, pregnant women, immunocompromised individuals and the elderly should be advised of the risks associated with the high prevalence of <i>L. monocytogenes</i> in ready-to-eat smoked fish products.	Ministry of Health Educational pamphlet released to pregnant women. Work occurred through Health Authorities to educate long term care facilities on RTE foods.	Completed
2) EVIDENCE-BASED SAMPLING The development of evidence-based sampling guidelines for industry and government for effective monitoring of <i>Listeria</i> spp. and <i>L. monocytogenes</i> (and other foodborne pathogens) in RTE food processing facilities and their products to include: facility environments and products to sample, sampling procedures, frequency of sampling, and recommended follow-up actions.	BC Center for Disease Control Finalizing recommendations to Ministry of Health in the DRAFT <i>Listeria in Ready-to-Eat Foods in Facilities under Provincial Inspection Authority, Recommendations from Working Group 2011</i> .	In Progress
3) EHO TRAINING Enhanced training for food inspectors on the identification and control of <i>Listeria</i> spp. in processing environments.	Ministry of Health MOU between Canadian Food Inspection Agency, the Department of Fisheries and Oceans, the Ministry of Agriculture, and the Ministry of Health to identify and clarify the roles regarding fish inspection programs and coordinated responses. Creation of fish inspection construction and operational checklists utilized by Health Authority, Environmental Health Officers (EHO) when inspecting seafood processing facilities.	In Progress
4) RTE FISH PRODUCTS It is clear from the results of this study that BC fish processing facilities producing ready-to-eat foods require special attention. The purpose of further study and of enhanced inspection should be to improve food safety for consumers of RTE fish products. Specific recommendations for fish processing facilities include:	BC Center for Disease Control continues to research RTE foods.	

¹ Occurrence and distribution of *Listeria* species in facilities producing ready-to-eat foods under provincial inspection authority in British Columbia FINAL REPORT
<http://www.bccdc.ca/NR/rdonlyres/659E872B-A803-4F99-8C6A-1902A143CCC7/0/ListeriaReportFINALwithAppendicesJan122011corrected.pdf>

a) RTE: FISH PRODUCTS – LIST OF RTE FISH PROCESSING FACILITIES Identification of all provincially licensed fish processing facilities currently producing RTE foods in order to better track output and performance.	Ministry of Health In process of creating a list of those seafood processing facilities that produce RTE foods.	In Progress
b) RTE: FISH PRODUCTS - HAZARD ANALYSIS CRITICAL CONTROL POINTS An assessment of Hazard Analysis Critical Control Points (HACCP) and other control measures in place in fish processing facilities, in conjunction with ongoing microbial testing of both the processing environment and foods to allow objective assessment of the effectiveness of means to audit and track facility hygiene.	Ministry of Health BC CDC is finalizing a Listeria Working Group report to be submitted to the Ministry of Health (2012). The report will assess HACCP and other control measures and recommend how/if these measures could/should be implemented. The report will be utilized to inform Ministry of Health's formation of policy direction.	In Progress
c) RTE: FISH PRODUCTS – LISTERIA IN SMALLER RTE PROCESSORS Encouragement of research into how <i>Listeria</i> enters and spreads through the processing environment of smaller RTE food producers.	BC Center for Disease Control BC CDC is finalizing a Listeria Working Group report that will provide recommendations on reducing/eliminating the spread of Listeria in seafood processing facilities.	Completed
d) RTE: FISH PRODUCTS – IDENTIFIED, DOCUMENTATION OF CONTROL MEASURES In the case of facilities where <i>Listeria</i> is identified, documentation of control measures where implemented, and their impact on the presence of <i>Listeria</i> in the processing environment and in fish products, to inform the optimal incorporation of practice-based learning into policies and procedures.	Ministry of Health In the process of evaluating food safety plan policies in seafood processing facilities. Ministry of Health is undertaking a seafood safety policy review to prevent or reduces the risk of food borne illness related to seafood processing for human consumption in BC.	In Progress
e) RTE: FISH PRODUCTS - LISTERIA WORKING GROUP Establishment of a working group of stakeholders including industry, BC Ministry of Agriculture and Lands, BC Ministry of Health Services, BC Regional Health Authorities and BCCDC to consider the results of this and subsequent surveys of fish processing facilities, seek out system improvements and outline future policy directions.	BC Center for Disease Control The Listeria Working Group will submit a final report to Ministry of Health in 2012. The working group includes members from the Ministry of Agriculture, Ministry of Health, BC Regional Health Authorities, BC Center for Disease Control, Health Canada and Canadian Food Inspection Agency.	Completed
5) RTE FISH PRODUCTS Additional sampling for <i>Listeria</i> spp. in BC inspected butcher and deli establishments which produce RTE meats and continuing vigilance by both operators and food safety inspectors for breeches of hygiene which suggest the possibility of contamination by <i>Listeria</i> spp. at any BC inspected RTE processor.	BC Center for Disease Control is in the process of developing a recommendation with accompanying protocol that would be required to implement this recommendation provincially.	In Progress

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff: 913572

PREPARED FOR: Graham Whitmarsh, Deputy Minister of Health - **FOR DECISION**

TITLE: Human Papillomavirus Vaccine Program for Young Women in British Columbia.

PURPOSE: To decide on implementation of a one-time only, catch-up extension
Human Papillomavirus Vaccine immunization program for young women within
BC Centre for Disease Control's existing vaccine budget

BACKGROUND:

The Human Papillomavirus (HPV) vaccine was introduced into BC's routine immunization program in 2008, with an initial 3 year catch-up program for Grade 9 girls, and an ongoing program for girls in Grade 6. As of June 2011, all girls up to Grade 12 have been offered this vaccine.¹ Those born prior to 1994 are not eligible for the publicly-funded program.

The National Advisory Committee on Immunization has recommended the HPV vaccine for females between 9-26 years of age, even if they are already sexually active, have had previous pap abnormalities, or have had a previous HPV infection.

Due to changes within the existing HPV immunization program, a one-time opportunity to offer a catch-up program to young women within the BC Centre for Disease Control's (BCCDC) vaccine purchase budget could be offered.

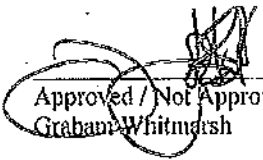
It is likely that new vaccines will be approved by Health Canada within the next year or two. Most prominent of these new vaccines is one for Meningococcal B.

DISCUSSION:

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1 of 4

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Approved / Not Approved
Grabant Whitmarsh

January 23/12
Date Signed

³ Other jurisdictions that have launched one-time catch-up programs for women have found uptake rates of approximately 30 percent.

⁴ Statement was made by Michael Marchbank, Executive Vice President, responsible for BCCDC.

⁵ See Appendix A

Program ADM/Division: Arlene Paton, ADM, Population and Public Health, 250-952-1731

Program Contact (for content): CDHM: Warren O'Brien, ED; Craig Thompson

Drafter: Craig Thompson, Director, Immunization Programmes

Date: January 20, 2012

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Appendix A

HPV Vaccine Working Group Organization Membership

BC Centre for Disease Control

Ministry of Health

BC Cancer Agency Cervical Cancer Screening Program

BC Cancer Agency, Population Oncology

BC Cancer Agency Colposcopy Program

Vaccine Evaluation Centre and BC Children's Hospital

BC Women's Hospital

PHSA/LMC Laboratories and Cervical Cancer Screening Program

Regional Health Authorities

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 925404

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

TITLE: Expansion of the School Milk BC Program

PURPOSE: S. 13, S. 17 expansion of the School Milk BC program as part
of the BC School Fruit and Vegetable Nutritional Program.

BACKGROUND:

School Milk BC is an initiative of the British Columbia Dairy Association, a not-for-profit organization whose goal is to increase milk consumption in BC students and to deliver nutrition education programs in BC schools. School Milk BC is an optional program in which students pay for the milk and schools make their own arrangements for the purchase and delivery of milk. The BC Dairy Association provides administrative tools to help schools keep track of who has ordered and paid for milk. There are 450 out of approximately 1200 BC elementary schools registered for the program but in some instances only 1 or 2 classes per school participate.

The BC School Fruit and Vegetable Nutritional Program (the Program), a partnership between the Ministries of Health, Education and Agriculture, provides BC-grown fresh fruit and vegetable snacks to students in all grades, 13 times per school year. All public and First Nation schools are eligible to apply for the Program and currently 1334 schools are registered. The Program is administered by the BC Agriculture in the Classroom Foundation.

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Rational:

- Thirty-seven percent of children between four and nine years of age are not consuming CFG's recommended servings of milk and alternatives.
- Milk is an excellent source of calcium and vitamin D, which are essential nutrients for bone growth and development. The recommendation for calcium is highest during childhood and adolescence when the rate of bone growth and development is highest. Milk is recommended over other food sources of calcium in the prevention of osteoporosis as it contains other important nutrients.
- A review of the Alberta School Milk Program showed increased consumption of calcium and vitamin D with the school milk program. A U.S. study found that students who received milk through the school meal program consumed more milk and fewer sugar sweetened beverages than those who did not participate in the program.

DISCUSSION:

Factors that support the expansion of School Milk BC:

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- The School Milk BC program aligns with the Healthy Families BC Schools goal of improving the health of school-age children. Providing milk supports the messages taught through Actions Schools! BC and Sip Smart! BC curriculum, which encourage children to minimize their consumption of sugar sweetened beverages and promote the consumption of healthier beverages.
- The School Milk BC program also supports the goal of the Healthy Families BC Schools initiative to enhance coordination and consolidation of provincial healthy schools initiatives and programs.
- Many schools have received fridges through both BC Dairy Association and the Program grants which ensure safe milk storage practices.
- The Program school coordinators have their food safety certificate and could distribute the milk at the same time as the fruit and vegetables.

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ADVICE:

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Program ADM/Division: Arlene Paton, Population and Public Health
Telephone: 250-952-1731
Program Contact (for content): Meghan Day, School Health and Priority Initiatives
Drafter: Melanie Kurrein
Date: April 19, 2012
File Name with Path: SAMCL\DOCS PROCESSING\Briefing Documents\2012\Approved\PH925404 - School Milk BC - Request for funding 2 (2).docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff: 926952

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health
Honourable Terry Lake, Minister of Environment
Honourable Rich Coleman, Minister of Energy and Mines
Honourable Blair Lekstrom, Minister of Transportation
Honourable Mary Polak, Minister of Aboriginal Relations and Reconciliation
– **FOR INFORMATION**

TITLE: Human Health Risk Assessment of the Oil and Gas Industry in Northeastern British Columbia – Phase 2

PURPOSE: To determine the next steps of Phase 2.

BACKGROUND:

Phase 1 of the risk assessment canvassed the public, local governments, First Nations, and other groups and individuals about their health concerns related to oil and gas activity (Appendix A). The associated Information Note and draft Media Release regarding release of the Phase 1 report includes a summary of the issues raised and is being lead by Government Communications and Public Engagement.

Phase 2 of the risk assessment is intended to look at the concerns raised in Phase 1 and conduct an independent review of existing research related to human health effects of the oil and gas industry and apply this information to northeastern BC.

The following excerpts from the original Phase 1 Request For Proposal (RFP) indicate expectations:

A follow-up to this stakeholder and targeted public engagement project will be a human health risk assessment of the oil and gas sector based on scientific review, incorporating the subject areas identified in the engagements from this project. The human health risk assessment will also involve a review of the risk management measures (such as monitoring, regulation, industry practice, and compliance) currently applied to deal with public health risks. Following the human health risk assessment, recommendations may be made for improving areas of the current regulatory, monitoring and industry (operational) practice systems.

There will be a public engagement process on the results of the human health risk assessment and management review.

Proponents are advised that the subsequent work (human health risk assessment) to this project will apply the general framework outlined in the Framework for Environmental Health Risk Management.

The Minister of Health's recent statement in the House with respect to Phase 2 is as follows:

Excerpt from Hansard May 10, 2012 Hon. M. de Jong: Just to give the member a bit of a chronology. The phase 1 report is done. The member may recall one of the members in the House asked about it a couple of days ago. I anticipate it being released in the next couple of weeks. What will happen now is we'll need to engage, and want to engage, the services of a third party to begin the process of compiling and assessing the scientific data on the basis of a set of terms of reference that are the result of the consultation that took place in phase 1. There may be some primary data collection, some air quality monitoring. But I don't want to suggest that there are going to be field laboratories set up across the northeast of the province. This will be relying

largely on the body of scientific data that is out there to assess what and where the risk exists.
That's probably going to be an 18-month exercise.

DISCUSSION:

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Program ADM/Division Arlene Paton, ADM, Population and Public Health
Telephone: 250 952-1731
Program Contact (for content): Tim Lambert, Executive Director, Health Protection
Drafter: Lidia Surman/Clyde Macdonald
Date: May 15, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\926952 - Human Health Risk Assessment Phase 2 for Joint Ministers Briefing.docx

APPENDIX A

SUMMARY OF THE FRASER BASIN REPORT – IDENTIFYING HEALTH CONCERNS RELATING TO OIL & GAS DEVELOPMENT IN NORTHEASTERN BC.

The report provides a balanced summary of the issues identified by stakeholders of northeastern BC. It takes a holistic and integrated approach in identifying the key issues of concern with over 300 unique comments or submissions. It summarizes what the Fraser Basin Council heard and is laid out in a very easy to read format. The report does not validate or analyze any of the issues identified, as this will be part of the Phase 2 Human Health Risk Assessment process. The report lays out a significant amount of background information for the reader to set the stage and provide an overall understanding of oil and gas development and history in northeastern BC.

A range of potential health issues have been raised – physiological, psychological and social/cultural – that relate to a range of sources. Some health issues, such as direct exposure to toxic emissions or contaminated water or food may be immediate and easily observed and measured, whereas others are less noticeable or difficult to substantiate, such as those from exposure to smaller quantities of toxins over time.

Based on respondents' concerns, the following seven theme categories were identified:

- Personal health issues;
- Environmental pathways of exposure;
- Related environmental issues;
- Changes to the community;
- Community service issues;
- Oil and gas operational issues; and
- Institutional framework issues.

The report also captured the respondents' suggested response to the issues they raised.

Personal health issues and environmental pathways of exposure: Although respondents recognize the contribution of oil and gas activity as a significant economic generator for northeastern BC, they may attribute personal health problems, such as asthma and bronchitis, cancer, stress and sleep deprivation, directly to exposure to oil and gas operations. Other examples of exposure concerns included exposure to hydrogen sulphide, contaminated water, diesel dust, and ingestion of adversely affected livestock and/or wildlife.

Related environmental issues: Some respondents expressed concerns about the risk of harm from incidents such as well-site accidents, pipeline leaks and spills, increased traffic, and noise and light pollution. Others were concerned about the health of ecosystems and the effect a contaminated ecosystem would have on their health and the health of their families.

Changes to the community and community services: Many respondents stated that rapid social and cultural changes could have effects on the socio-economic and demographic structure of their communities, resulting in increasing pressure on existing health care services, social and community services, and municipal and regional infrastructure.

Oil and gas operational issues: One of the most common issues raised was hydraulic fracturing and the perception that this activity could lead to seismic activity, water quality and quantity issues, or the potential to trigger sour gas releases.

Institutional issues: These include monitoring and compliance, regulation and enforcement, communications emergency response, and tracking and reporting of adverse health effects. Some respondents were dissatisfied by what they saw as insufficient information available to them from both the government and the oil and gas sector, and a lack of transparency with respect to specific oil and gas development activity.

Overall, the respondents appreciated having ample opportunity and options for providing input in Phase 1, they made it clear they wanted the momentum from Phase 1 to continue.

The concern of many respondents was uncertainty and not being fully informed of the extent and nature of possible long-term health effects on individuals and communities within close proximity of oil and gas operations. Some are frustrated and want some of their concerns resolved by the regulator (e.g., Oil and Gas Commission), the provincial government, Northern Health Authority, and the oil and gas companies.

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #927138

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

TITLE: Meeting with Barbara Kaminsky, CEO, Canadian Cancer Society,
British Columbia and Yukon

PURPOSE: The CEO of the Canadian Cancer Society (CCS), BC and Yukon,
regarding partnering with the CCS on cancer-reduction measures. Agenda
topics are:

1. Government support for the Cancer Prevention Centre
2. Province-wide colorectal cancer-screening program
3. Province-wide cosmetic pesticide legislation
4. Ensuring tanning bed legislation is implemented.

This information note addresses topics 3 and 4

PROVINCE-WIDE COSMETIC PESTICIDE LEGISLATION:

The CCS, other nongovernmental organizations and members of the public are calling for phasing out the use of cosmetic pesticides. There is enough concern about the potential human and environmental health hazards of cosmetic pesticides to promote policies that minimize unnecessary exposures to any pesticide.

The BC Ministry of Environment (MoE) administers the sale, use and handling of pesticides in the province under the *Integrated Pest Management Act* and Regulation. MoE promotes an integrated pest management approach to preventing pest problems. This involves monitoring the number and types of pests in an area and using control techniques that have the least impact on people, property and the environment.

On June 2, 2011, the Legislative Assembly agreed that the Special Committee on Cosmetic Pesticides be appointed to make recommendations on the unnecessary use of pesticides in BC and conduct consultations with the public and key stakeholders.

The committee is tasked with considering:

- the scope of any ban on the sale and use of pesticides, including those used solely for cosmetic purposes; and
- any appropriate exemptions and restrictions on the sale and use.

The committee has received over 8,700 submissions and has heard from regulators, toxicologists, health organizations, environmentalists, industry representatives, diverse business sectors, municipalities, and local pesticide coalitions. The public had the opportunity to provide input by filling in an e-questionnaire, or submitting written or videotaped comments.

The committee is currently considering feedback from the public and stakeholders on the cosmetic use of pesticides to develop report recommendations. It expects to table its report during the spring sitting of the Legislative Assembly.

TANNING BED LEGISLATION:

Minister de Jong announced on March 20, 2012, that the Province will ban commercial indoor tanning bed use by young people under the age of 18. The announcement was made shortly after the release of a report by the Indoor Tanning Working Group, established at the Minister's request in September 2011 to provide options regarding the use of commercial indoor tanning equipment by minors.

Work has commenced on the proposed regulation under the *Public Health Act*, which is anticipated to take effect in the fall of 2012. The working group provided options on other aspects of commercial indoor tanning to support the ban. The Province has expressed interest in continuing to work with medical organizations, stakeholder groups and the tanning bed industry to analyze and implement these options, which are as follows:

- require provincially approved training for all owners and operators of tanning equipment;
- require tanning beds to be controlled by an onsite trained operator;
- require UV-radiation warning signs to be posted in all tanning facilities, and a health-risk fact sheet distributed to all potential clients;
- implement a provincial tanning-equipment licensing framework (licence to operate) if it can be achieved with minimal cost to operators and the BC Government/health authorities; and
- prohibit misleading medical and health claims about indoor tanning.

Program ADM/Division:	Arlene Paton, ADM, Population and Public Health
Telephone:	250-952-1731
Program Contact (for content):	Tim Lambert, Executive Director, Health Protection
Drafter:	Andrea Careless
Date:	May 2, 2012
File Name with Path:	Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\PH\927138 - Meeting with Barbara Kaminsky CEO Canadian Cancer Society BC and Yukon.docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927207

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

TITLE: Cancer Prevention Centre Proposal

PURPOSE: To provide background information for meeting May 9th with Barbara Kaminsky from the Canadian Cancer Society (CCS) regarding a proposal for a Cancer Prevention Centre.

BACKGROUND:

- The CCS, BC and Yukon, in partnership with the University of British Columbia (UBC), is seeking \$25 million as a one-time grant for the capital cost of building a Cancer Prevention Centre (the Centre). This represents half of the Centre's estimated cost.
- The "National CCS-UBC Cancer Prevention Centre" would be created in association with the Research Chair in the Primary Prevention of Cancer, located at the UBC School of Population and Public Health. The research chair position was created in 2008 in part with \$4 million from the Province. Research Chairs are funded through The Leading Edge Endowment Fund, created by the BC Government in 2002 to encourage social and economic development in the province.
- The goal of the Centre would be to "generate and translate new knowledge through research and apply that research to policies, programs and practices sooner." It would seek to link academia, the CCS, BC Cancer Agency, health care providers, government and the public. It would also seek to influence policy decisions and program delivery by increasing the profile of cancer prevention research.
- In an overview package of information provided to the Premier's office in February (attached), the CCS included one of the projects undertaken by the Centre, as an example of how it provides "timely and useful benefits for the Ministry of Health (the Ministry), the provincial government, and ultimately for all British Columbians." The Province is partnering with the CCS on the WellnessFits program, which is intended to serve as the Healthy Families BC workplace health promotion component. WellnessFits is the subject of a study being conducted by the Research Chair on the program's effectiveness. The Centre proposes to conduct "knowledge translation" work on the study to improve the program's effectiveness.

DISCUSSION:

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S. 13 S. 17

ADVICE:

S. 13 s. 17

Program ADM/Division: Arlene Paton, ADM, Population and Public Health

Telephone: 250-952-1731

Program Contact (for content): Tom Gregory, Executive Director
Business Operations and Surveillance

Drafter: Barb Callander

Date: May 2, 2012

File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing

Documents\2012\Approved\PH\927207 - Cancer Prevention Centre Proposal.doc

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927701

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

TITLE: Loblaw Companies Limited Meeting

PURPOSE: To provide information on Loblaw Companies Limited for the Minister of Health's meeting scheduled for Thursday, May 10, 2012 from 4:30pm to 5pm .

BACKGROUND:

Loblaw Companies Limited is British Columbia's largest food retailer with 75 stores throughout the province. Loblaw stores include Real Canadian Superstore, Extra Foods, and *no-frills* in Western Canada. Loblaws also has a large food distribution network and provides pharmacy services, general merchandise and financial products. They have demonstrated their commitment to health with the recent announcement on May 3, 2012, to remove artificial colours and flavours from their signature President's Choice line of products.

There is a growing consumer interest in health and wellness. Building on this consumer trend, the Province has the opportunity to explore grocers' potential role in collaborating with the BC Ministry of Health to promote healthier choices.

S. 13, S. 17

DISCUSSION:

Efforts to promote healthy eating and lifestyles:

The Healthy Families BC strategy, announced by Premier Christy Clark in May 2011, is the Ministry of Health's approach to encourage all British Columbians to lead healthier lives where they live, work, learn, and play. The strategy assists families in making healthy choices and introduces innovative approaches to challenges facing the health care system. Healthy Families BC focuses on a variety of measures that target investments and efforts in initiatives that will measurably address physical inactivity, unhealthy eating, and obesity, through four key elements: Healthy Eating, Healthy Start, Healthy Communities, and Healthy Lifestyles.

Possible healthy living partnerships with the Ministry of Health:

Grocers play a key role in accessibility and affordability of foods in communities across our province. In-store health promotion strategies can influence British Columbians to make healthier food choices that support the Province's health improvement and prevention strategy to reduce chronic illness. The most effective and/or promising health promotion practices in-store include:

- grocery store tours;
- pricing strategies;
- shelf-space allocation to healthier foods;
- in-store educational brochures and interactive displays;
- nutrition labelling education strategies; and
- multiple component strategies like supermarket flyers, coupons, incentive programs, store signage, in-store food demonstrations, and tasting opportunities.

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ADVICE:

The Ministry of Health is keen to partner with grocers on in-store health promotion strategies that can influence British Columbians to make healthier choices. Loblaws has the opportunity to partner with the Ministry of Health on the promotion of Healthy Families BC's new virtual grocery store web-based tool, Shopping Sense. If Loblaws wishes to discuss tobacco sales in pharmacies, the Minister could take their information under advisement.

Program ADM/Division: Arlene Paton, ADM, Population and Public Health
Telephone: 250-952-1731
Program Contact (for content): Lisa Forster-Coull, Provincial Nutritionist, 250-952-1124
Drafter: Lisa Forster-Coull, Provincial Nutritionist, 250-952-1124
Date: May 7, 2012
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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927757

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

TITLE: Meeting with Tim Hortons re: Informed Dining Program

PURPOSE: To provide background information on Tim Horton's involvement
and potential concerns with the Informed Dining Program:

BACKGROUND:

British Columbia's new restaurant program, Informed Dining is a component of the Province's Healthy Families BC campaign to reduce obesity and prevent chronic disease. Announced on August 10, 2011, the program is voluntary for the private sector but will be mandatory for food service establishments in health care facilities through a phased in approach between 2013 and 2015 (See Appendix A).

Tim Hortons represents 257 quick service restaurant outlets in BC, making them the third largest chain restaurant in the province, after Starbucks (370 outlets) and Subway (275 outlets). There are seven Tim Hortons' kiosks that will be affected by the mandate in health care facilities, six of which are operated by Compass Group Canada and located throughout Provincial Health Services Authority, Fraser Health Authority, and Vancouver Island Health Authority. The seventh kiosk is operated directly by Northern Health Authority.

Tim Hortons is a member of the Canadian Restaurant and Foodservices Association and has been involved in consultations with the Federal/Provincial/Territorial Task Group on Provision of Nutrition Information in Restaurants and Foodservices.

Tim Hortons currently provides customers with a nutrition guide (See Appendix B) in the form of an 8 ½ x 17 colour brochure available to customers at the ordering counter and also provides customers with nutrition information on-line.

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DISCUSSION:

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The Informed Dining Program has been mandated by government directive in health care facilities. Tim Hortons kiosks in health authorities will be required to implement the Informed Dining in Health Care Program, through a phased in approach between 2013 and 2015. Program staff have consulted with health authorities and further consultations are planned later this spring with contracted vendors to review the program standards, determine if any adaptations are required for the health care setting and determine the impact on existing contractual arrangements. Tim Hortons is aware of these plans and will be included in the consultation process.

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ADVICE:

The Ministry welcomes Tim Hortons participation in the Informed Dining Program. Their participation would demonstrate leadership and commitment to healthy eating and healthy lifestyles. Program staff will re-engage Tim Hortons and work collaboratively to get them fully implemented in the private sector program and engage them in the consultation process for implementation in health care.

Program ADM/Division:	Arlene Paton, Assistant Deputy Minister, Population and Public Health
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Program Contact (for content):	Lisa Forster Coull, Provincial Nutritionist
Drafter:	Lorrie Cramb, Senior Manager, Public Health Nutrition
Date:	May 15, 2012
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NEWS RELEASE

For Immediate Release
2011HLTH0054-000982
Aug. 10, 2011

Ministry of Health

B.C. restaurants help families make informed choices

VICTORIA – Enjoying a meal out at a restaurant can be a fun and enjoyable way for families to spend time together.

Now the B.C. restaurant industry is partnering with the Province to provide restaurant customers with the information they need to make the healthy choice the easy choice.

The \$1.9-million Healthy Families BC – Informed Dining program will give customers the information they need to make healthier choices when eating out. Participating restaurants will add the Informed Dining program logo and a statement on their menu or menu board, letting customers know that nutrition information for all standard menu items is available upon request. Restaurants will provide nutrition information (similar to what is currently found on packaged foods) before or at the point of ordering in the restaurant. Information may be provided on a brochure, a menu insert or poster.

Calorie and sodium content will be highlighted, and restaurants must also include information on daily sodium and calorie requirements. Customers will then be able to make informed choices when choosing meals for themselves or their children.

It is estimated that Canadians currently purchase one in ten meals or snacks from a restaurant. By providing nutrition information in restaurants, customers can make decisions that will help to promote healthy weights and prevent high blood pressure and chronic illnesses such as cardiovascular disease, diabetes and cancer.

The Informed Dining program is a component of the Province's Healthy Families BC (www.HealthyFamiliesBC.ca) campaign to reduce obesity and prevent chronic disease. It has been developed in collaboration with the Canadian Restaurant and Food Services Association, the BC Restaurant and Food Services Association, the Heart and Stroke Foundation of BC and Yukon, chain and independent restaurant leaders and public health partners. Although voluntary for private retail food services, the program will be mandated in food service establishments in health-care facilities.

The Province has been working with the restaurant industry for several years to help protect the health of British Columbians. In 2009, B.C. was the first jurisdiction in Canada to regulate the use of trans fat in restaurants and food service establishments.

Quotes:

Minister of Health Michael de Jong –

"Knowledge is power. By providing nutrition information – especially calorie and sodium information – in restaurants, we are able to help make the healthy choice the easy choice for British Columbians and their families."

Ian Tostenson, CEO and president, BC Restaurant and Food Services Association –

"We all have a responsibility to contribute to the health of the next generation. I am very pleased that we are able to work with the Province to promote good health and provide options and information for our customers."

Mark von Schellwitz, vice-president, Canadian Restaurant and Foodservices Association, Western Canada –

"We want to be part of the solution in making healthy choices easy choices in B.C. Our priority is a national nutrition disclosure framework and B.C.'s Informed Dining program is an important first step. This program has the potential to help restaurant patrons become more conscious about what they are eating. It also shines a light on those establishments already providing menu nutrition content while encouraging other restaurants to follow suit."

Diego Marchese, CEO of the Heart and Stroke Foundation of BC & Yukon –

"Healthy eating is a critical element in living a long and healthy life and avoiding cardiovascular disease. The Province's Informed Dining program takes a positive step forward in providing people with information they can use in making informed choices while dining out. The program acts to level the playing field by revealing important nutrient information in dining establishments that is currently only available on packaged foods. This is definitely a step in the right direction for furthering the health of British Columbians."

Quick Facts:

- According to the BCRFA, there are about 12,000 restaurants in British Columbia.
- Nutrition labelling of pre-packaged food is already regulated by the Canadian Food Inspection Agency.
- Cardiovascular disease, diabetes and cancer are estimated to cost our health-care system between \$730 million and \$830 million per year.
- Reducing sodium intake could prevent up to 23,500 cardiovascular events such as heart attack and stroke per year, and could generate direct savings of \$1.38 billion annually.
- The Canadian Council of Food and Nutrition reported that in 2006, of all the money spent on food in Canada, 40 per cent is spent in food service outlets.
- People who eat more sodium than needed are at greater risk from high blood pressure, which is a major risk factor for stroke, heart disease and kidney disease.
- British Columbians consume more than double the amount of sodium considered adequate to promote good health in B.C., as recommended by Health Canada.

- Nutrition information disclosure in restaurants and food services is one of the key recommendations from the Sodium Working Group report, Sodium Reduction Strategy for Canada, and the Public Health Agency of Canada report, Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights.

A backgrounder follows.

Contact: Ministry of Health
250 952-1889 (media line)

Connect with the Province of B.C. at: www.gov.bc.ca/connect

BACKGROUNDER

For Immediate Release
2011HLTH0054-000982
Aug. 10, 2011

Ministry of Health

Healthy Families BC – Informed Dining

Informed Dining

The Healthy Families BC—Informed Dining program is designed to promote restaurants that have committed to provide customers with nutrition information for all of its standard menu items. It has been created in collaboration with the restaurant and food service industry and public health stakeholders.

All restaurants in B.C. are eligible to participate in the voluntary program. The program will be mandatory for food service establishments in health-care facilities. The Province encourages restaurant owners and managers to join in the fight to prevent obesity and chronic diseases by providing this important nutritional information to their customers.

To participate in the program, restaurants must meet the following criteria:

- Restaurants must disclose nutrition information for all standard menu items. Calorie and sodium content must be highlighted.
- Restaurants must include the Informed Dining logo and directional statement that is prominently displayed on the menu or menu board indicating that nutrition information is available.
For example: (Name of restaurant) proudly offers nutrition information to help guests make informed choices. Please see our menu insert for more information.
- Restaurants must include information regarding daily calorie and sodium requirements.

Participating restaurants will display the Informed Dining program name and logo on their menus and marketing materials to promote their participation in the program and to encourage customers to ask for nutritional information.

Provincial environmental health officers will be monitoring for compliance in restaurants as part of their regular food safety inspections.

The Province will provide support to participating restaurants with marketing and promotional efforts through the Healthy Families BC website and other media opportunities.

Contact: Ministry of Health
250 952-1889 (media line)

Connect with the Province of B.C. at: www.gov.bc.ca/connect

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 928073

PREPARED FOR: Honourable Michael de Jong, QC, Minister of Health, and
Dr. Moira Stilwell, Parliamentary Secretary to the Minister of Health
- FOR INFORMATION

TITLE: 30th Annual Meeting of Federal/Provincial/Territorial Ministers
Responsible for the Status of Women

PURPOSE: To report outcomes of the 30th Annual Federal/Provincial/Territorial
(FPT) Meeting of Ministers Responsible for the Status of Women,
May 2 and 3, 2012.

BACKGROUND:

The FPT Ministers Responsible for the Status of Women Forum was established in 1981. The purpose is to share information on initiatives and emerging issues; collaborate on joint policies; and co-operate in developing joint projects to increase public awareness about women's issues across the country.

The Forum's work is accomplished through three levels:

1. Ministers
2. Corresponding Senior Officials
3. Senior Officials Working Groups: Jurisdictions choose which of the groups they will participate on or lead. The federal government traditionally co-chairs each working group which includes: Aboriginal Women's Issues; Violence Against Women; and Women's Economic Security. British Columbia is a member of the first two working groups.

Canada co-chairs the Forum with an annually rotating province or territory as a host jurisdiction. BC last hosted a Ministers' meeting and co-chaired the Forum in 2000/01.

DISCUSSION:

The 30th Annual Minister's Meeting was held in Halifax, Nova Scotia on May 2 and 3, 2012 (see Appendix A). It was co-chaired by Honourable Rona Ambrose, Minister of Public Works and Government Services, and Minister for Status of Women. The provincial co-chair and co-host was Honourable Marilyn More, Minister responsible for the Nova Scotia Advisory Council on the Status of Women.

Ministers or delegated MLAs attended from Saskatchewan, Manitoba, New Brunswick, Nova Scotia, Newfoundland, Prince Edward Island, and the Northwest Territories. Remaining jurisdictions (Alberta, Ontario, Quebec, Nunavut, and Yukon) were represented by Senior Officials. Joan Geber, Executive Director, Healthy Women, Children and Youth Secretariat attended as the Senior Official on behalf of BC.

In celebration of the 30th annual meeting, the Ministers adopted the Halifax Declaration which reaffirmed their commitment to improving the status of women and girls by addressing the inequalities that continue to limit their social, economic and cultural well-being (see Appendix B).

The meeting focused on the following issues:

Violence Against Women

Ministers acknowledged the work in the area of trafficking in persons, and directed Senior Officials to find more opportunities to collaborate in this and other violence against women areas, recognizing the multiple partners attempting to address these issues. Ministers directed Senior Officials to continue working with Statistics Canada to update *Measuring Violence Against Women: Statistical Trends 2006*, with the anticipated release in 2013, and to support the work of Justice Canada on the topic of the economic impact of violence against women. Ministers also directed Senior Officials to undertake focussed work engaging men and boys in violence prevention; presentations included the White Ribbon Campaign (centred on the pledge to never commit, condone or remain silent about violence against women and girls), and the Respect Group (founded by Sheldon Kennedy and centred on abuse, bullying and harassment prevention).

Economic Security of Women

Ministers directed Senior Officials to continue to support the work of promoting the recruitment and retention of women in non-traditional fields such as science, engineering, trades, and technology. Ministers directed Senior Officials to continue to undertake focussed work in the area of women in leadership and to raise awareness of the issue of representation of women in public and private leadership appointments. The Conference Board of Canada presented on the lack of progress in numbers of women in senior management. Staff from "Women Unlimited" presented on their program which assists unemployed/underemployed women to prepare for, obtain and maintain employment in trades and technology fields. Following the meeting, a policy forum that focused on the under representation of women in science, engineering, trades, and technology was held.

Aboriginal Women

Ministers directed Senior Officials to examine the issues of Aboriginal women in leadership positions and engaging men and boys in the prevention of violence against Aboriginal women.

The formal Record of Decisions is expected shortly. The next Ministers meeting will be held in June 2013 with Prince Edward Island as host province.

ADVICE:

S. 13

Program ADM/Division:	Arlene Paton, A/ADM, Population and Public Health
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Date:	May 15, 2012
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Status of Women Canada

News Release

Ministers Responsible for the Status of Women Reaffirm Their Commitment to Address Priority Issues for Women: Economic Security, Leadership, and Ending Violence

May 3, 2012

HALIFAX - Federal-Provincial-Territorial (FPT) Ministers Responsible for the Status of Women gathered in Halifax on May 2 and 3, 2012. The annual meeting was co-chaired by the Honourable Rona Ambrose, Canada's Minister of Public Works and Government Services and Minister for Status of Women, and the Honourable Marilyn More, Minister responsible for the Nova Scotia Advisory Council on the Status of Women.

The meeting provided a valuable opportunity for Ministers to exchange insights and discuss developments in the priority areas of improving women's economic security, promoting women's leadership and ending violence against women, each with an ongoing focus on Aboriginal women.

FPT Ministers explored new avenues for advancing women's economic security. In their discussions on emerging issues and best practices, Ministers benefited from the expertise of non-governmental organizations working to promote girls and women in leadership roles and non-traditional occupations in science, engineering and the trades. They also learned about specific initiatives aimed at increasing Aboriginal women's and girls' participation in leadership and decision making.

FPT Ministers reaffirmed their commitment to ending violence against women and girls and the importance of engaging all Canadians on this issue. After hearing from leaders in this field, Ministers discussed the most effective ways to reach out to and work meaningfully with men and boys toward this end. They agreed that men and boys must be active participants and allies in solving this enduring problem.

The Ministers look forward to the release, proposed for 2013, of their jointly produced *Measuring Violence Against Women: Statistical Trends*. Last issued in 2006, the Statistics Canada publication presents national data on the major indicators of violence against women, including up-to-date details on the nature and extent of violence against women.

In recognition of the forum's 30th anniversary and its valuable work to advance equality for women over the intervening years, FPT Ministers issued the *Halifax Declaration* (attached). While acknowledging past efforts, the forward-looking document emphasizes current priorities and plans for the future.

Prince Edward Island will host the next meeting in 2013.

[Read the statement](#)

For more information, please contact:

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Ce texte est également disponible en français.

Date Modified: 2012-05-03



Status of Women Canada

Statement

May 3, 2012

Halifax Declaration by the Ministers Responsible for the Status of Women on the Occasion of Their 30th Annual Meeting in Halifax

Preamble

We, the Ministers Responsible for the Status of Women, recognize that women and men are equally integral to Canada's prosperity and success in the world.

We are proud to have been able to work as a federal-provincial-territorial forum dedicated to the status of women, addressing issues of importance to Canadian women since we began meeting in 1981. Over that time, we have examined key concerns in the areas of women's health, women's economic security, Aboriginal women's issues and violence against women.

We have helped to advance equality for women in a number of concrete ways by:

- working with other federal-provincial-territorial bodies on issues of mutual concern in the areas of health, labour and justice;
- releasing statistical reports on violence against women that are used by governments, non-governmental women's organizations, academics, and others involved in the policy process to address this serious issue and guide future progress;
- developing material to support the economic advancement of women, including resources to help employers create workplaces that attract, retain and promote women; and
- hosting policy forums to support women's employment in sciences, engineering, trades and technology, and to explore solutions to end violence against Aboriginal women.

We are pleased to have witnessed significant advancements in the status of women in recent decades. However, we recognize that inequalities persist and that further efforts are needed to empower women and girls, particularly the most vulnerable in our communities.

We are humbled by those who have led the way in advancing women's full participation in all aspects of society, and we are inspired by the energy and intelligence of the young women and girls who are following in their footsteps.

As we work to strengthen the status of women, we are also championing the rights of women and girls everywhere. We therefore look forward to the first-ever International Day of the Girl on October 11, 2012, celebrating girls and young women as citizens and as powerful voices of change.

Declaration

We, Ministers Responsible for the Status of Women, on the occasion of our 30th annual meeting, reaffirm our commitment to improve the status of women and girls by addressing the inequalities that continue to limit their social, economic and cultural well-being.

On the first International Day of the Girl on October 11, 2012, we will celebrate girls as powerful agents of change, and we will focus on ways to ensure they reach their full potential. We invite all Canadians to join us in celebrating this new annual event.

We are committed to examining concerns of particular importance to girls in our future efforts and actions.

We have made great strides in advancing gender analysis within our governments, and in ensuring the unique needs and experiences of diverse groups of Canadian women and girls are reflected in public policies and programs. We will continue to promote these practices within our governments. We encourage the use of gender and diversity analysis throughout civil society.

We recognize the crucial role that men and boys can play in preventing violence against women and girls. By engaging all Canadians in efforts to end violence and achieve equality for women and girls, we believe we can bring about a better society for all.

We acknowledge that equality for women and girls can only be achieved through the coordinated and sustained efforts of all governments, communities and individuals. As Ministers Responsible for the Status of Women, we pledge to pursue our shared goals while taking all necessary actions to advance equality and improve the lives of women and girls within our respective jurisdictions.

May 2012

Date Modified: 2012-05-03

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #: 928265

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

TITLE: Mobile Slaughter Establishment in 100 Mile House

PURPOSE: To provide information on the use of mobile slaughter establishments in the 100 Mile House region to address local slaughter needs.

BACKGROUND:

Residents of 100 Mile House have been vocal about their desire to have more options for local slaughter services other than the existing licensed slaughter establishments in the region. Recently, community members have rallied around a proposal that MLA Barnett has put forth to allow Findlay Meats Ltd. to continue to operate without the required provincial upgrades with a local veterinarian providing inspection services. The proposal assumes the Province of BC would pay for the local veterinarian time.

The options to the community are to use existing licensed slaughter establishments, apply for Class E licenses where applicable, or to build a provincially licensed slaughter establishment, which could be a mobile slaughter establishment.

DISCUSSION:

Mobile slaughter establishments are an innovative approach that allows multiple communities to be served by a single slaughter establishment. A mobile slaughter establishment can be well suited for locations where livestock numbers are too low to make a fixed establishment financially viable, and can assist with the challenges of transporting livestock over long distances. Mobile slaughter establishments are often built for one species and for smaller animal numbers. For example, the red meat mobile slaughter establishment in Fort St. John was built into a semi trailer unit and can process ten animals daily.

In order to operate, a mobile slaughter establishment requires an approved docking station that meets provincial standards in each location it offers services. Docking station requirements are contingent on the particular design of the mobile slaughter establishment, which will influence costs. Other cost factors include location, access to water, waste disposal options and whether the station is intended to operate seasonally or year-round. Based on these variables, docking station costs can range from \$5,000 to \$10,000 for poultry and \$15,000 to \$30,000 for red meat.

S. 13

Operation costs for mobile slaughter establishments can be higher due to fuel costs for transporting the mobile slaughter establishment to its docking stations, as well as maintenance costs incurred through greater wear and tear. Currently, a number of poultry mobile slaughter establishments are operating as stationary plants because producers are not willing to pay for increased transportation costs (resulting from rising fuel prices) in order to bring the mobile slaughter establishment to the community.

Inspector time for a mobile slaughter establishment has also been a challenge for certain areas in the province, as one inspector is assigned to follow the mobile slaughter establishment. This can lead to excessive travel and overtime costs if the multiple docking stations are scheduled for service over several days.

ADVICE:

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Provincially Licensed Mobile Slaughter Establishments:

Red Meat:

Gate to Plate Food Services Inc.

This establishment has multiple docking stations in the area of Fort St. John

Ph: 250-785-7738

Email: stj2005@telus.net

Poultry:

Cariboo Central Interior Poultry Producers Association

This establishment has docking stations in Quesnel and Prince George, with another planned in 100 Mile House

Ph. 250-992-1511

Email: info.ccippa@gmail.com

Web: www.ccippa.ca

Okanagan Poultry Processing

This establishment is now fixed, and is based in Kelowna

Ph. 778-477-4004

Email: peggy@okpoultryprocessing.com

Web: <http://okpoultryprocessing.com/>

Passmore Poultry Pluckers Inc.

This establishment is fixed, and is based in Passmore

Phone. 250-226-7100

Email: mortonjudi@hotmail.com

Web: www.passmorepluckers.ca

Creston Valley Poultry Processing Ltd.

This establishment is fixed, and is based in Creston

Ph. 250-428-7013

The Pluckin' Maniacs

This establishment has docking stations to the west and north of Kamloops

Ph. 250-314-1007

Email: twespy@gmail.com

Website: <http://plucknmaniacs.com>

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 903841

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

TITLE: Meeting with the Catholic Women's League of Canada

PURPOSE: To advise the Minister of Health about the result of the meeting with the Catholic Women's League of Canada, British Columbia & Yukon Provincial Council, to discuss their Resolutions: 2011.01 Prohibition of Practices re Human Reproductive Material, and 2011.02 Respect and Protection for Human Embryos and Human Reproductive Material.

BACKGROUND:

The Catholic Women's League of Canada, BC & Yukon Provincial Council (the Council) requested a meeting with the Minister of Health (the Minister) on October 28, 2011, to discuss Resolutions 2011.01 and 2011.02. The Minister directed Ministry of Health (MoH) staff to meet with the Council on his behalf. The Council requested a meeting be held March 2012.

On March 14, 2012, MoH staff met with Nancy Simms, the Council's President, Doreen Gowans, President-elect, and Pat Deppiesse, 2nd Vice-President, with expectations of discussing Resolutions 2011.01 and 2011.02.

Resolutions 2011.01 and 2011.02 were developed in response to the Supreme Court of Canada ruling in December 2010, on the constitutional challenge of *The Assisted Human Reproduction Act* of 2004 (the Act) by the Quebec Government. The court ruled in favour of Quebec and deemed 10 sections of the Act exceeded the legislative authority of Parliament, and are rather within provincial jurisdiction. These sections concern regulations and/or statutes for human embryos, reproductive material and licensing, which presently do not exist at the provincial level.

The Council is particularly concerned with Sections 10 and 11 of the Act. Section 10 prohibits alteration or manipulation of human reproductive material for the purpose of creating an embryo; Section 11 prohibits combining human genomes with those of another species. The Council is urging the Government of BC to implement regulations and licensing standards that will protect the handling of human embryos and reproductive materials. They suggest the Government of BC collaborate with other provincial and territorial governments to ensure consistent regulations across Canada.

Unexpectedly, the Council presented an additional 4 Resolutions: 2010.01 Strategies for Alzheimer's and Related Dementias; 2010.02 Chrysotile Asbestos; 2011.03 National Organ and Tissue Donation and Transplantation Registry; and 2011.04 Caffeine in Energy Drinks. The package the Council delivered to the MoH staff that outlines their Resolutions is attached (Appendix A).

DISCUSSION:

As a Catholic institution, the Council considers their Resolutions 2011.01 and 2011.02 to be of utmost importance because they believe human embryos are total, unique human beings; they equate the mishandling of human embryos on par with human trafficking.

MoH staff assured the Council that MoH is aware of the ruling and understands that the province will need to consider next steps to this ruling.

The Council was encouraged to seek and respond to the mechanisms designed for public input for regulation development. The Catholic Women's League of Canada's national delegation met with federal government officials in November 2011, and the Council met with their BC MLAs, regarding their Resolutions 2011.01 and 2011.02.

MoH staff also promised to forward the information regarding the additional Resolutions on to the Provincial Health Officer and other appropriate MoH branches.

ADVICE:

The MoH encourages the Council to continue to seek and respond to the mechanisms available for public input with regard to their issues of concern.

Program ADM/Division:	Arlene Paton/Population and Public Health
Telephone:	250-952-1731
Program Contact:	Joan Geber, Executive Director, Healthy Women, Children and Youth Secretariat, 205-952-3678
Drafter:	Sara McLaughlin, Manager, Women's Health, Healthy Women, Children and Youth Secretariat
Date:	March 28, 2012
File Name with Path:	Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\P&PII\903841 - Catholic Women's League of Canada - Human Reproductive Material.doc

**The Catholic Women's League of Canada
BC & Yukon Council**

RE: Information for Health Minister Regarding CWL Resolutions

**Respect and Protection for Human Embryos and Human Reproductive Material
Prohibition of Practices re Human Reproductive Material**

I would like to bring to your attention, resolution BC2011.02 *Respect & Protection for Human Embryos and Human Reproductive Material*.

On December 22, 2010 the Supreme Court of Canada ruled on the constitutional challenge from the Quebec government who felt that sections of The Assisted Human Reproduction Act of 2004 infringed on provincial powers. The Court deemed many sections of the Act exceeded the legislative authority of Parliament, thus in fact removing them from federal jurisdiction and placing them under the provinces and territories where regulations and/or statutes for human embryos, reproductive material and licensing do not presently exist.

In total, 10 sections of the Act are now under provincial jurisdiction and are presently without regulations. I would like to share with you in part sections 10 & 11 to clarify the importance of the need for statutes or regulations as well as licensing for human embryos and reproductive material. Section 10 (1) reads:

10. (1) No person shall, except in accordance with the regulations and a licence, alter, manipulate or treat any human reproductive material for the purpose of creating an embryo.

In other words, since this section is now under provincial jurisdiction and our province has no regulations, there is presently nothing stopping any person from altering or manipulating human reproductive material to create embryos. Section 10 (3) reads:

(3) No person shall, except in accordance with the regulations and a licence, obtain, store, transfer, destroy, import or export

(a) a sperm or ovum, or any part of one, for the purpose of creating an embryo; or

(b) an *in vitro* embryo, for any purpose.

This means that since our province, as well as other provinces is without regulations on this, any person could, without penalty, destroy embryos and/or import and export them anywhere in the world.

Human embryos *are* total, unique human beings that only need time for complete development. They deserve respectful handling and protection. Neither embryos nor human reproductive material should be treated as commodities. This would be tantamount to the allowance of human trafficking.

Section 11 (1) reads:

11. (1) No person shall, except in accordance with the regulations and a licence, combine any part or any proportion of the human genome specified in the regulations with any part of the genome of a species specified in the regulations.

Therefore, we are presently without regulations for scientists to combine human DNA with other species. The ramifications of not having regulations on matters as important as this are beyond imagination. And this is just part of two of the ten sections currently without statutes, regulations and licensing.

BC must immediately implement regulations that will provide protection and respectful standards in the handling of human embryos and regulations for the handling of human reproductive material as well as all the licensing required.

Also, to avoid competition between provinces and territories we would ask the government of BC to make efforts to meet with other provincial and territorial governments of Canada to develop consistent respectful regulations throughout the country.

In addition to asking for provinces and territories to create regulations and statutes, the national council of the CWL has a resolution, which is in your package today, urging the federal government to *prohibit absolutely* practices of alteration, manipulation and treatment of human reproductive material that result in the destruction of human embryos. During the 2010 court proceedings the Supreme Court of Canada noted that parliament *could* have absolutely prohibited these practises and therefore we are asking them to do so. But until this happens, each province and territory needs to develop the regulations and licensing to protect the handling of reproductive material and human embryos. The very essence of human dignity is at stake here and immediate action needs to be taken.

BC2011.02 Respect and Protection for Human Embryos and Human Reproductive Material

Whereas, provincial and territorial governments now need statutes and/or regulations for the handling of human embryos, reproductive material, and licensing due to the Supreme Court of Canada Decision (Dec. 2010) which deemed sections of the Assisted Human Reproduction Act (2004) as unconstitutional and under provincial jurisdiction; and

Whereas, the lack of statutes and regulations could lead to the mishandling of human reproductive material and the abuse of human embryos which deserve respect and protection; therefore be it

Resolved, that the BC & Yukon Council of the Catholic Women's League of Canada urge the BC and Yukon governments to implement regulations that would provide protection and respectful standards in the handling of human embryos, and regulations on the handling of human reproductive material, and licensing; and be it further

Resolved, that this resolution be forwarded through the national executive of The Catholic Women's League of Canada, to the other provincial and territorial councils:

- encouraging them to bring this need for regulation and standards to the attention of their own provincial and territorial governments for action, and to
- encourage all provincial and territorial governments to convene consultative meetings immediately to develop consistent and respectful national regulations in the handling of human embryos, reproductive material and licensing, and therefore, be it

Resolved, that this resolution be forwarded to the national council for consideration at the 2011 annual national convention.

1 **BRIEF: BC2011.02 Respect and Protection for Human Embryos and Human**
2 **Reproductive Material**

3 The Supreme Court of Canada (Dec. 2010) ruled on the constitutional challenge by the
4 Quebec government regarding The Assisted Human Reproduction Act (2004) (the Act).
5 The ruling deemed Sections 10, 11, 13, 14 to 18, 40(2)(3)(3.1)(4)(5) and 44(2)(3) as
6 exceeding legislative authority of Parliament thus agreeing these were under provincial
7 jurisdiction. (McLachlin et al) Due to the Supreme Court ruling, provinces and
8 territories that lack statutes or regulations now need them for the handling of human
9 embryos, reproductive material and licensing.

10 Since human embryos are total, unique human beings that only need time for complete
11 development, they deserve respectful handling and protection. As well, reproductive
12 material must not be treated as commodities but require regulations and licensing. The
13 Act defines human reproductive material as "a sperm, ovum or other human cell or a
14 human gene, and includes a part of any of them." (the Act, section 3) . Since these
15 sections of the Act are now deemed to be under provincial jurisdiction, the lack of
16 statutes and/or regulations could lead to abuses of human embryos and human
17 reproductive material which could include exporting, importing, research and
18 destruction. (section 10, 11, 13, 14, 16(3), 18, 40(2)(3)(3.1)).

19 We urge the BC and Yukon governments to implement regulations immediately that
20 would provide protection and respectful standards in the handling of human embryos,
21 and regulations for the handling of reproductive material as well as all the licensing
22 required. Through our National Council we ask that all Provincial Councils bring this to
23 their own provincial and territorial governments asking that immediate efforts be made
24 by these governments to meet and develop consistent and respectful regulations
25 throughout the country in regards to the handling of human embryos, reproductive
26 material and licensing.

27 Our society has a responsibility to take immediate action. To quote His Grace
28 Archbishop Richard Smith, "We're talking about a fundamental question of life itself and
29 dignity of human life, this is a consideration that transcends provincial and national
30 boundaries." (Gyapong)

**REFERENCES: BC2011.02 Respect and Protection for Human Embryos
and Human Reproductive Material**

Assisted Human Reproduction Act 2004

Gyapong, Deborah, **Supreme Court ruling casts out genetic research barriers**,
Western Catholic Reporter, January 17th, 2011

McLachlin C.J. and Binnie, LeBel, Deschamps, Fish, Abella, Charron, Rothstein and
Cromwell JJ. Supreme Court of Canada Decision re Assisted Human Reproduction Act
2004

**Christian Family Life
B.C. & Yukon Provincial Council**

2011.01 Prohibition of Practices re Human Reproductive Material

Whereas, The *Assisted Human Reproduction Act* imposes only selective regulations for the practices of alteration, manipulation and treatment of human reproductive material; and

Whereas, The Supreme Court of Canada noted that parliament could have prohibited absolutely the practices of alteration, manipulation and treatment of human reproductive material; and

Whereas, Manipulation and mistreatment of human reproductive material may result in the destruction of human embryos; therefore, be it

Resolved, That the national council of The Catholic Women's League of Canada in 91st annual national convention assembled urge the federal government to prohibit absolutely practices of alteration, manipulation and treatment of human reproductive material that result in the destruction of human embryos.

BRIEF: Prohibition of Practices re Human Reproductive Material

The *Assisted Human Reproduction Act* (2004) (the *Act*) imposed some regulations on the practices of alterations, manipulation and treatment of human reproductive material (*Act*, s. 5), including sections 10 and 11, summarized below:

The Supreme Court of Canada noted that parliament could have “prohibit[ed] absolutely the practices ... of altering, manipulation and treatment of human reproductive material” (*Reference re SCC 61*, para. 101) which refers to “sperm, ovum or other human cell or a human gene, and includes a part of any of them” (*Act*, s. 3).

Section 10: No person shall ... alter, manipulate or treat any human reproductive material for the purpose of creating an embryo.

Section 11: No person shall ... combine any part or any proportion of the human genome ... with any part of the genome of [another] species.

The Supreme Court indicated that it is within criminal law to control the combining of any part of the human genome with any part of the genome of another species (*Reference re SCC 61*, para. 107). Genome is the DNA of a particular cell (*Act*, s. 3).

The League urges the federal government to prohibit absolutely the practices of alteration, manipulation and treatment of human reproductive material that would result in the destruction of human embryos and/or the combining of species.

WORKS CITED:

Assisted Human Reproduction Act (2004, c. 2)

<http://laws-lois.justice.gc.ca/eng/acts/A-13.4/FullText.html>

Reference re Assisted Human Reproduction Act, 2010 SCC 61, [2010] 3 S.C.R. 457.

<http://scc.lexum.org/en/2010/2010scc61/2010scc61.html>

Page 316 to/à Page 337

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 912738

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

S. 12, S. 13, S. 17

Pages 408 through 413 redacted for the following reasons:

S. 12, S. 13, S. 17
S. 12, S. 13, S. 17

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff #917457

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

TITLE: Midwives Association of BC

PURPOSE: Background information concerning Midwifery.

BACKGROUND:

Midwives in BC offer primary health care for healthy pregnant women and their newborn babies from early pregnancy, through labour and birth, and up to six weeks postpartum. The College of Midwives is the regulatory body for Midwives. The Midwives Association of BC (MABC) is the professional organization which represents Midwives in its negotiations and collaboration with other parties, including the Ministry of Health.

Midwives were paid approximately \$19.3 million for clinical services and managed approximately 6,345 Full Courses of Care (births) in BC. As of September 26, 2011, there were 218 registered midwives, of whom 187 were in active practice. This means the average number of births managed per Midwife is 35. Current MSP payments for Midwifery services is based on rates in place March 31, 2010 and carried forward to March 31, 2012.

The Minister of Health, the Honourable Michael de Jong, met with the MABC on December 8, 2011. He requested MABC clarify their three priorities for improving maternity care in BC and their response dated December 23, 2011, is summarized below and attached.

DISCUSSION:

S. 13, S. 17

Pages 415 through 428 redacted for the following reasons:

S. 13 s 17

S. 13, s 17

S. 13, s 17

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 919109

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

TITLE: Midwives Association of BC (MABC): Priority Issues

PURPOSE: Information for teleconference with MABC scheduled
February 17, 2012

BACKGROUND:

Midwives in BC offer primary health care for healthy pregnant women and their newborn babies from early pregnancy, through labour and birth, and up to six weeks postpartum. The College of Midwives is the regulatory body for Midwives. The Midwives Association of BC (MABC) is the professional organization which represents Midwives in its negotiations and collaboration with other parties, including the Ministry of Health (the Ministry).

The current Agreement with the MABC expires March 31, 2012. The Agreement includes provisions which enable payment for services to continue in the event that the contract is not renewed by the end of the Term. Either party may initiate negotiations through written notice to the other party. Neither the MABC nor the Ministry has done this.

The Minister of Health, the Honourable Michael de Jong, (the Minister) met with the MABC on December 8, 2011. He requested the MABC clarify its top three priorities for improving maternity care in BC. The Minister reviewed those three priorities with Ministry staff by teleconference on February 8, 2012.

DISCUSSION:

S. 13, S. 17

S. 13, S. 17

ADVICE:

S. 13, S. 17

Program ADM/Division: Nichola Manning, A/ADM, Medical Services and Human Resources Division
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Drafter: Beverlee Sealey
Date: February 16, 2012
File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Pending\919109 - Midwives Association of BC teleconference.docx

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 920429

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

TITLE: Meeting with Regional Advisory Committee (RAC), Royal College
of Physicians and Surgeons of Canada (Royal College),
April 21, 2012, 10:30-11:30am in Vancouver

PURPOSE: To provide background information for meeting on April 21, 2012
with RAC of the Royal College

BACKGROUND:

The Royal College sets the standards for specialty medical education in Canada and supports lifelong learning for specialist physicians.

Five Regional Advisory Committees (RAC) of the Royal College across Canada contribute regional perspectives. The British Columbia Minister of Health is speaking at a RAC meeting in Vancouver on April 21, 2012.

S. 13

DISCUSSION:

S. 13

ADVICE:

The Royal College's leadership can make a difference in medical education.

- **We value distributed medical education.** It is important to train the right people in the right places with the right skills to deliver the right services. We must train more physicians who will serve populations in rural settings.
- **We value generalism.** We must not narrow residents' practice scope early in training. We value the generalist specialist in rural medicine who has a broad practice scope.

Program ADM/Division: Nichola Manning, Medical Services and Health Human Resources Division
Program Contact (content): Libby Posgate, Executive Director, HHRP (Physicians)
Drafter: Shelly Anderson, Senior Policy Analyst, HHRP (Physicians)
Date: April 16, 2012
File Name with Path: S:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\920429 - Regional Advisory Committee and Royal College of Physicians and Surgeons of Canada.doc

Pages 433 through 437 redacted for the following reasons:

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MINISTRY OF HEALTH INFORMATION BRIEFING DOCUMENT

Cliff# 921671

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

TITLE: Meeting with College of Family Physicians

PURPOSE: To summarize the BC College of Family Physicians Medical Home vision related to current initiatives underway in Primary Health Care.

BACKGROUND:

In September 2011 the BCCFP published: *A Vision for Canada: Family Practice - The Patients Medical Home*. Input to this paper was provided by 60 organizations and governments/100 individuals across Canada. The Patients Medical Home model describes a standard for a patient-centred primary health care system that provinces can use in building upon current family practices (whether solo, group, rural, urban) and primary care improvement initiatives. This model promotes bringing together under one roof (physically or virtually), a network of health care professionals to foster better collaboration and coordination of care to improve patient outcomes.

Under this model the family physician and nurse represent the primary network for a patient and manages the inclusion of other health professionals such as psychologists, social workers, and dietitians as required. To what degree a network is established varies based on the size of the community. For smaller rural locations this could mean a family physician establishing a virtual link to other health professionals. For large urban centers it could mean having another health professional such as a dietitian physically present at the clinic. The primary objective of this model is that every person in Canada has the opportunity to be part of a family practice that serves as a patient's medical home.

Other priorities by the College include: increasing same-day service; better coordination of referrals; promotion of strategies for chronic disease management; establishing links between primary care and public health; and increased use of electronic medical records.

DISCUSSION:

The Ministry, in partnership with key stakeholders to the Primary Health Care Charter¹ currently has a number of initiatives underway intended to encourage similar attributes and outcomes for patients as with the medical home model. For example, the Ministry's Innovation and Change Agenda, Integrated Primary and Community Care (IPCC) seeks to establish a primary health care system that is continuous, comprehensive, coordinated, accessible and built around patient attachment to a family physician and an extended health care team primarily provided by health authorities with links to local community services. The target population for IPCC includes patients with chronic, co-morbid and or complex needs, women in pregnancy, patients with mental illness, and fragile elderly patients. Currently

¹ BC Ministry of Health, Primary Health Care Charter,
http://www.health.gov.bc.ca/library/publications/year/2007/phc_charter.pdf

26 communities are at various stages of implementing key elements of IPCC.

Additional initiatives which promote similar principles, priorities and outcomes for patients identified by the BCCFP under the *Patient's Medical Home* model include:

- **GP4ME:** The goal of A GP4Me is to attach the 400,000 British Columbians without a family physician or who do not have strong attachment to a family physician. Memorandums of Understanding have been signed with three Divisions of Family Practice to develop a framework for attachment that can be used by other divisions. These three divisions cover a population of 11 communities (259,367 people) and eight more communities are interested in taking on this initiative.
- **Advance access module (Practice Support Program)** has provided patients faster access to their GP. Through this program 74 percent of physicians who participated in the Advanced Access learning module said they had reduced patient wait times for regular appointments and 49 percent reduced wait times for urgent appointments.
- In order to increase access to patients in need of palliative care services the ministry in partnership with the Health Authorities and HealthLink BC has committed to providing after-hours access to community palliative care services.
- **Chronic Disease Management:** Through the introduction of additional payments the General Practice Services Committee has provided incentives for general practitioners to develop shared care plans with patients and other providers and to conference with other health professionals such as specialists and specialty care nurses around those plans. These payments promote a planned, proactive, evidence based approach to improving patient care.
- **Patients as Partners:** At the individual level, BC is focused on advancing self-management supports through partnership with community and non-governmental organizations to empower patients, families and caregivers (17,000 people have been trained to date in chronic disease self-management). At the community and system redesign level, patients are involved through Patient Voices Network and there is a focus towards increasing Patient and Public Engagement training, mentoring and coaching for patients and providers (IAP2 training, Practice Support Program etc).
- The ministry has supported physician adoption of EMRs and related technology through the Physician Information Technology Office initiative since 2006. As of February 2012, 2,448 physicians have either implemented, or are in the queue to implement an EMR application through this initiative. The ministry is also supporting the integration of EMRs with established provincial Electronic Health Record repositories (e.g., PharmaNet and the client registry).

ADVICE:

- The Patients Medical Home model provides valuable insight and best practices that the provinces can look to in moving towards a patient-centred primary health care system.
- The current approach in BC focuses on promoting similar principles, attributes and aims for patients and providers within the BC context.

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Date: April 11, 2012,

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**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff# 921859

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

TITLE: Union Involvement in Alleged Elder Abuse Involving Health Care Assistants (HCAs)

PURPOSE: To provide information on regarding the Union's involvement to protect members that have been accused of elder abuse, as well as resolutions.

BACKGROUND:

- As of January 12, 2010, Health Employers Association of BC (HEABC), BC Government Employees Union (BCGEU), Facilities Bargaining Association (FBA), and Community Bargaining Association (CBA) entered into an agreement regarding the process for investigation of Residential Care Aides and Community Health Workers in cases of alleged elder abuse. This process involves the union grievance process and the BC Care Aide and Community Health Worker Registry (the Registry) investigation.¹
- Currently the Registry is mandatory only for service providers that receive public funding; there is no cost to the Employer or registrant to become registered. All publicly funded employers are required to report to the Registry – in writing – every termination or suspension of an HCA for alleged abuse.
- The Registry's purpose is not to discipline HCAs; it only registers, suspends or removes registrants in response to an employer's action of suspension or termination of an employee for alleged abuse of a patient, resident or client. The removal of a registrant from the Registry will affect their ability to hold employment as a health care worker.
- Removal from the Registry may be for a limited time period with conditions, or it can be permanent. When an HCA is removed from the registry, the grievance process through the Union is the individual's initial option. If no agreement is reached between the employer and the Union, the Union can request an investigation from a Registry appointed investigator. HCAs without union representation may also request this process.
- The individual's final status on the registry will depend on the employer's proposed resolution or the findings of the appointed Registry investigator. If the Union or the employer does not agree with the findings, arbitration is the final option. All investigations are managed in confidentiality with the employer, unions, and the HCA only.

¹ Appendix A: BC Care Aide & Community Health Worker Registry – Process for Removal from the Registry

DISCUSSION

- Removal from the Registry is dependent on the employer as a reporting mechanism in cases of alleged abuse. Reported cases of alleged abuse refer to actions that result in suspension or termination of the HCA on the part of the employer.
- We have heard anecdotal reports regarding some employers may be addressing issues of potential abuse outside the agreed to process (e.g. negotiating an agreement that removes the employee from the worksite). There is currently no mechanism for tracking these types of claims.
- Since the implementation of the agreement regarding the Registry process, there have been 80 cases of alleged abuse by Care Aides or Community Health Workers. Of these 80 cases, there were three instances in which the Union grievance process resulted in the reinstatement of accused individuals on the Registry without any request for investigation through the Registry from the union.²
- 52 of the 80 alleged abuses cases resulted in employee termination. Of these 52 cases, the union has requested an investigation from the Registry appointed investigator in 31 instances. Six of these investigations are outstanding, while 26 have been completed. The Union has not challenged the findings of the Registry investigator in any of these cases.

ADVICE

- Although the Registry was implemented in 2010, full implementation was to occur through a phased in process.
- The Ministry, working with HealthMatch BC, monitors the progress of the Registry, as well as concerns being raised for potential further action.
- The fact that the Union has not challenged the findings of the Registry investigator is a strong indicator that the process is effective.

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File Name with Path: Y:\MCU\DOCS PROCESSING\Briefing Documents\2012\Approved\MSHHRD\921859 - INFO BN - Minister Request - Union Involvement Elder Abuse Care Aides- ED APRVD.docx	

² Bruce Bell, Manager, BC Care Aide and Community Health Worker Registry – Conversation, March 12, 2012

APPENDIX A

BC CARE AIDE & COMMUNITY HEALTH WORKER REGISTRY

Process for Removal from the Registry

Dated: January 12, 2010

-
- 1) The Registry process is intended to support and improve quality care, training, access to employment and the recognition of care aides, community health workers and other occupations requiring the BC health care assistant certificate that are not regulated by statute.
 - 2) The Registry process will apply to all service providers who receive public funding (direct or indirect funding from the BC government) whether they are unionized or non-union and whether they are HEABC members or are not HEABC members. For clarity the Registry process applies to contractors to those service providers.
 - 3) Removal from the Registry may only occur where an employee of a facility or service provider is terminated for abuse.
 - 4) The definition of "abuse" for these purposes is the same as definition set out in the *Residential Care Regulation* part 5, division 2, section 52 (1) (a) of the *Community Care and Assisted Living Act* that states "A licensee must ensure that a person in care is not, while under the care or supervision of the licensee, subjected to
 - (a) financial abuse, emotional abuse, physical abuse, sexual abuse or neglect as those terms are defined in section 1 of Schedule D, or
 - (b) deprivation of food or fluids as a form of punishment."
 - 5) As a matter of its contract with the Ministry or with a Health Authority, an employer in receipt of public funding is required to report to the Registry in writing every suspension pending the investigation for alleged abuse or termination of an employee for alleged abuse.
 - 6) A report of suspension of an employee for alleged abuse or termination of an employee for alleged abuse must be made in writing within seven (7) calendar days of the employer's notification to the employee of the suspension or termination and must:
 - (a) identify the employee suspended pending investigation for alleged abuse or terminated for alleged abuse;
 - (b) the nature of the allegation of abuse against the employee;
 - 7) A copy of the report to the Registry must be provided to the employee, the Registry and to the union designate, (where the employee suspended or terminated is represented by a union).
 - 8) Where an employee is suspended pending the results of the employer's disciplinary investigation, the employee will be suspended from the Registry until the completion of the investigation or, if the employee is not registered, will not be registered until the investigation is completed.

- 9) (a) An employer may suspend an employee pending the result of an investigation of alleged patient, client or resident abuse, with or without pay but where an investigation is not completed within twenty-one (21) calendar days, the continued suspension by the employer must be with pay until the completion of the employer's investigation;
- (b) For the purposes of this process, "with pay" after twenty-one (21) calendar days means the employee's average weekly earnings for the sixty (60) calendar days prior to the suspension excluding leave(s) without pay;
- 10) An employee terminated by an employer for alleged abuse will remain suspended from the Registry until the employee is reinstated through the grievance procedure (in the case of an employee represented by a union) or until resolution of any dispute over the decision to terminate from the Registry as outlined in this process.
- 11) Where the employee is represented by a union, the employer must advise the Registry forthwith in writing if a suspended or terminated employee is reinstated through the grievance procedure and where an employee is reinstated to employment through the grievance procedure the employee will be reinstated to the Registry.
- 12) The following procedure applies to an employee represented by a union who is terminated by an employer for alleged abuse and not reinstated through the grievance process under the collective agreement:
- (a) where the employee is not reinstated up to and including Step 3 of the grievance procedure, the employee will remain suspended from the Registry at least until such time as the employee is reinstated to the Registry through this process;
- (b) If the employee is not reinstated through the grievance procedure up to and including Step 3, the union representing the employee may withdraw the grievance in which case the employee will remain suspended from the Registry or the union may request appointment of an investigator under the Registry;
- (c) a union requesting an investigator must submit the dispute to the Registry in writing identifying the name of the employer, the name of the employee, the date of termination and the name of the union person responsible for the grievance;
- (d) within ten (10) calendar days of receipt of the request from the union, the Registry will appoint the first available investigator from the list below to mediate the dispute over termination of the employee and resulting suspension from the Registry;
- (e) the investigator will inquire into the differences between the employer and the union over the termination and will endeavour to assist the parties in resolving their differences;
- (f) In undertaking an investigation, the investigator:
- (i) must determine his or her own procedure, but must give an opportunity to an interested party to present evidence and make representations;
- (ii) may receive and accept the evidence and information on oath, affidavit or otherwise that, in his or her discretion, he or she considers advisable, whether or not admissible as evidence in a court of law; and will

- (iii) confer with the parties and may conduct hearings;
- (g) the investigator must, after completion of the investigation, recommend in writing with reasons whether:
 - (i) the termination of the employee should be sustained or not sustained;
 - (ii) if the termination is not sustained, an alternate remedy should be utilized; and,
 - (iii) if the investigator determines that the employee should remain suspended from the Registry, the investigator may determine the length of any suspension and may attach conditions necessary for the employee's reinstatement to the Registry;
- (h) If the parties are unable to agree on the facts in the dispute, the investigator must set out in the report the facts agreed by the parties and the issues of the facts on which the parties do not agree;
- (i) If, during the course of the investigation, the parties reach agreement on the outstanding issues, the investigator must reflect that agreement in his or her report;
- (j) the employer and the union will share all costs of the investigator;
- (k) Investigators must be drawn from the following list of which four (4) will be finalized by the parties:
 - Lisa Hansen
 - Mark Atkinson
 - Paula Butler
 - Debbie Cameron
 - Jean Greatbatch
 - Kate Young
- 13 (a) If either of the parties reject the recommendations of the investigator, the parties may proceed to arbitration under the collective agreement and the report of the investigator is not admissible in that arbitration and the investigator is not compellable as a witness;
- (b) In addition to the powers conferred upon him or her by the collective agreement and the *Labour Relations Code*, an arbitrator appointed by the parties to adjudicate their differences over the termination of an employee, must also decide if the employee should remain suspended from the Registry and the duration of that suspension including any conditions required for reinstatement to the Registry;
- (14) The following procedure applies to an employee not represented by a union or where a union representing an employee decided not to proceed to the investigation phase or to arbitration and who was terminated by an employer for alleged abuse:
 - (a) an employee who is terminated by an employer who is not represented by a union will remain suspended from the Registry until such time as she or he is reinstated through this process;
 - (b) the employer must set out for the Registry the basis on which it terminated the employee and a copy of this report will be provided to the employee within seven (7) calendar days of the employer's notification to the employee of the suspension or termination;

- (c) such an employee may apply in writing and within 30 days from the date of the termination to the Registry for appointment of an Investigator from the list below and within ten (10) calendar days of receipt of the request from the employee, the Registry will appoint the first available Investigator from the list below to mediate the dispute over termination of the employee and resulting suspension from the Registry;
- (d) an employee has a right to representation during an investigation;
- (e) the Registry will be responsible for the costs of the investigator;
- (f) when an investigator is appointed, the investigator:
 - (i) must determine his or her own procedure, but must give an opportunity to an interested party to present evidence and make representations;
 - (ii) may receive and accept the evidence and information on oath, affidavit or otherwise that, in his or her discretion, he or she considers advisable, whether or not admissible as evidence in a court of law;
 - (iii) will confer with the parties and may conduct hearings;
 - (iv) after concluding the investigation, must report to the employee, the employer and the Registry in writing advising whether the employee should be reinstated to the Registry or continue to be suspended from the Registry;
 - (v) determine whether or not that employee should remain suspended from the Registry, the investigator may determine the length of any suspension and may attach conditions necessary for the employee's reinstatement to the Registry;
- (g) Investigators must be drawn from the following list of which four (4) will be finalized by the parties:
 - Lisa Hansen
 - Mark Atkinson
 - Paula Butler
 - Debbie Cameron
 - Jean Greatbatch
 - Kate Young
- (15) With the agreement of HEABC and the unions, the Registry may replace one or more of the Investigators.
- (16) The process outlined in this document will be part of a letter of understanding signed by the parties.

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 922918

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

TITLE: Anesthesia Withdrawal of Services - Options

S. 13, S. 17

Pages 467 through 469 redacted for the following reasons:

S. 13 S. 17

S. 13, S. 17

**MINISTRY OF HEALTH
DECISION BRIEFING NOTE**

Cliff # 927942 x ref #927151

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

S. 12, S. 13

Pages 471 through 473 redacted for the following reasons:

S. 12, S. 13

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 926836

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

TITLE: Health Data Research and Privacy Law in British Columbia, and
The Data Effect – Conference, June 5, 2012

PURPOSE: To provide background and context for *The Data Effect* conference
(See the related briefing note: Open Data).

BACKGROUND:

The Ministry of Health (the Ministry) recognizes the potential of its provincial healthcare databases and the value that access to this data has for researchers, healthcare professionals and the British Columbia health system. However, secondary use, data linkage and research present unique privacy concerns and the Ministry has a responsibility to ensure appropriate protection of the personal health information that it holds in trust. It is possible, and necessary, to enable appropriate data access for research purposes, while still protecting individual privacy.

The Ministry's historical relationship with the British Columbia research community is best illustrated by describing its 20 year engagement with the University of British Columbia (UBC). This relationship dates back to the mid 1980s when UBC developed the BC Linked Health Database using personalized data from Ministry data sources. This database continues to be used to provision data extracts to researchers, for which there is a cost recovery program in place to the benefit of UBC. Over the years, funding amounts to UBC varied, however, records show \$1,000,000 in annual grants between 2006/07 and 2008/09, and no monies in 2009/10 due to the grant freeze. In 2010/11 the Ministry and UBC entered into a 3 year service agreement for UBC to provide administrative and data provisioning services on behalf of the Ministry.

The BC Linked Health Database is now administered as part of Population Data BC (located within UBC), a multi-university research organization with a research advancement agenda. Population Data BC has acquired additional data holdings from sources including BC Cancer Agency, Worksafe BC, and Vital Statistics Agency.

Population Data BC currently provides linked, patient-level, de-identified Ministry data for about 20 third party research projects annually. Many of these projects are multi-year initiatives requiring additional data and amendments to the original data extract over time. Since 2000, the Ministry has approved over 200 third party research data projects.

There is a conference in Vancouver, June 5, 2012 called *The Data Effect* to discuss the lack of available and timely research data access. The Government is concurrently working on its Open Data strategy, however, Open Data is not the focus of *The Data Effect* conference. Government is also currently debating a new *Pharmaceutical Services Act* under Bill 35. Bill 35 is also not the focus of *The Data Effect*.

DISCUSSION:

Privacy laws are not the 'roadblock' to research; however, the confused legislative and regulatory environment may be. The British Columbia health sector is governed by a complex framework of laws, regulations, policies and codes of practice, resulting in a legislative and regulatory environment that is challenging. Some provinces in Canada have enacted health specific access and privacy legislation. The Ministry is studying this approach.

Research data access in British Columbia has not always been as timely or efficient as it could have been. While it is true that past requests were known to take upwards of a year or more to process, significant progress has been made over the past year with the introduction of a three year service agreement with UBC to administer data requests and provision data, Ministry staff's reconciliation of the backlog of academic data requests (25+), and a commitment by the Ministry to adjudicate data requests meeting set criteria within three months.

The Ministry has approved 200+ third party academic data requests in the past ten years. The current queue for academic data requests is at its lowest since 2003.

In May 2011, the Ministry demonstrated its commitment to academic health research by building a unique training dataset using the Ministry's de-identified patient data to train in the classroom and over a secure server the academic data researchers of tomorrow. The Population Health Data Analysis Program at UBC has proven to be highly successful and is currently being expanded.

In September 2011, the Ministry committed to adjudicating data requests that meet set criteria within three months of receipt by UBC. Together with UBC, the Ministry devised a set of criteria in order to ensure that privacy legislation and access protocols are met at the time of submission.

ADVICE:

The Ministry's academic data access program has been subject to vast criticism for lack of timely data access and available adjudication criteria. However, much success has been made during the past couple years and continued success is anticipated due to the three year service agreement, the reconciliation of the data request backlog, and the current strength of the Ministry's partnership with UBC. A comprehensive data access review is currently underway and recommendations are expected to be implemented later this year. The research community has made its needs clear to the Ministry, and the Ministry continues to undertake new initiatives to respond.

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Drafter: Melissa Murdock, A/Director, Data Research, SPIMDS

Date: May 8, 2012

File Name with Path

Key Messages - Privacy & Researcher Access to Ministry Databases:

1. We live in the information age. Powerful information technology capabilities provide for collection, use, linkage, manipulation, access, and sharing of large volumes of information in unprecedented ways. The Ministry of Health recognizes the potential of its provincial healthcare databases and the value that access to this data has for researchers, healthcare professionals and the British Columbian health system. However, secondary use, data linkage and research present unique privacy concerns and the Ministry of Health has a responsibility to ensure appropriate protection of the personal health information that it holds in trust. It is possible, and necessary, to enable appropriate data access for research purposes, while still protecting individual privacy.
2. Privacy laws are not the 'roadblock' to research; the confused legislative and regulatory environment may be.

The British Columbia health sector is governed by a complex framework of policies, codes of practice, laws and regulations that address confidentiality, privacy and security specifically, as well as a large volume of other laws that intersect with these. The result is a confused legislative and regulatory environment that is challenging for administrators, healthcare professionals and the public. In contrast, six (soon to be seven) jurisdictions in Canada have enacted health-specific access and privacy legislation.¹ There is evidence to suggest that stand-alone health information legislation works by ensuring one common set of rules.

The case for stand-alone health information legislation was made to Leadership Council with the health authority CEOs in March 2012, and is supported by British Columbia's Office of the Information and Privacy Commissioner.

3. The Ministry of Health recognizes that there is room for improvement in its current processes for researcher access to provincial health-care databases. A comprehensive data access review is currently underway and recommendations are expected to be implemented later this year.

¹ Six jurisdictions in Canada (Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, and Newfoundland and Labrador) have enacted health-specific access and privacy legislation; Nova Scotia has also passed its *Personal Health Information Act*, although it has not yet been proclaimed in force (anticipated winter 2012/12).

**MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE**

Cliff # 927449

PREPARED FOR: Honourable Micheal de Jong, Q.C., Minister of Health -
FOR INFORMATION

TITLE: Ministry of Health Open Data

PURPOSE: To brief the Minister on the Ministry's Open Data initiative in advance of "The Data Effect" conference in Vancouver on June 5 and, in particular, to distinguish between researchers' data needs and "Open Data".

BACKGROUND:

The Data Effect conference is subtitled: *Explore our hidden opportunity*. Its premise is: *"If implemented responsibly, this public resource [data] has the potential to save lives, reduce health care costs by billions of dollars and further develop a powerful life science sector."* <http://www.thedataeffect.org/> See Appendix A for a list of conference speakers.

"Open data" are anonymized data, stripped of personal identifiers or aggregated to a level that an individual's personal information is unlikely to be revealed when a data user combines ministry Open Data sets with data sets from other public or private sector sources. "Open" means the data are available in machine-readable formats such that users can manipulate the data. BC's Open Data has few conditions on its use.

Much of the Ministry of Health's (the Ministry) data is originally created, not in the ministry but where the health services are delivered to individual citizens, such as in the health authorities for acute care, home and community care, mental and public health services, to name some. Data will be in proprietary and often in non-machine-readable formats. If selected for "open" data, they first require conversion from their original data collection formats. Because of the personal identifiers in most health data, they also cannot be released as "open data" without first summarizing to some aggregate level to protect privacy. Some health data sets are too small to protect patient identity and, therefore, are not suitable for release as "open data" but, related to the Data Effect conference, may have value to health research.

Population Data BC gives "researchers access to health care, health services and population health data, and a comprehensive education and training service on how to best use those data"¹. Appendix B lists health data currently available via Population Data BC. Also see the related briefing note (Cliff# 926836): *Research Data Access in BC*. A research agreement is required to access health data for research purposes, the process of which is described in the *Research Data Access Framework* provided with note #926836. The Ministry confirmed an *Open Data Implementation Plan* for 2012/13, also provided with this note. The plan sets out criteria (Appendix C) for selecting health data for release as open data, in accordance with the new *BC Open Information and Open Data Policy*.² By policy, personally identifiable data will not be released as open data through Data BC.

¹ <http://www.popdata.bc.ca/>

² Open Information and Open Data Policy, link: http://www.cio.gov.bc.ca/local/cio/kis/pdfs/open_data.pdf

DISCUSSION:

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Recent media articles³ report that medical researchers feel it is almost impossible to access the Ministry's extensive data assets. A key difference between the BC Open Data initiative and researchers' use of health data is the potential participation in a research study by individuals who are identified in the health data. Health researchers are bound by ethical considerations⁴ and in some cases, study participants' consent; whereas, the BC Open Data initiative specifically excludes person-specific data or data that could potentially identify an individual or reveal personal information. As such, health open data are unlikely to satisfy all of the more specialized requirements of health researchers.

ADVICE:

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File Name with Path:	

³ As one example: Globe and Mail, 18 April 2012. *Plan to unlock B.C.'s trove of medical data raises privacy concerns.*

⁴ *Tri-Council Statement: Ethical Conduct for Research Involving Humans*
http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf (216 pages)

Appendix A: The Data Effect Conferences Speakers

<http://www.thedataeffect.org/speakers/>

Bill Barrable
CEO, Rick Hansen Institute

Dr. Khaled El Emam
Canada Research Chair in E-Health Information, University of Ottawa

Dr. Diane Finegood
President and CEO, Michael Smith Foundation for Health Research

Dr. Patricia Martens,
Director, Manitoba Centre for Health Policy

Dr. Julio Montaner
Director, BC Center for Excellence in HIV/AIDS (by video)

Dr. Bruce Carleton,
BC Children's Hospital, Chair of Provincial Data Stewardship Committee

Dr. Thomas Kerr,
Co-Director, Urban Research Initiative, BC Center for Excellence in HIV/AIDS

Don Enns
President, Life Sciences British Columbia

Elizabeth Denham
Information and Privacy Commissioner for British Columbia, Canada

Colin Hansen,
MLA, Former Health and Finance Minister

Nancy Meagher,
Executive Director, Population Data BC

Appendix B: Health Data Currently Available via PopDataBC.

From: <http://www.popdata.bc.ca/data-available-overview>

Search this site:

FOR RESEARCHERS

FOR RESEARCHERS

DATA AVAILABLE

OVERVIEW

HEALTH CARE & HEALTH SERVICES DATA

POPULATION & DEMOGRAPHIC DATA

OCCUPATIONAL DATA

EARLY CHILDHOOD DEVELOPMENT DATA

ICIS SPATIAL DATA

EDUCATION & TRAINING

Page last revised: February 1, 2012

DATA AVAILABLE

Internal data holdings

- Health care and health services data
 - Medical Services Plan Payment Information (MSP)
 - Pharmacare
 - Discharge Abstract Database (Hospital Separations)
 - Home and Community Care (Continuing Care)
 - Mental Health
 - BC Cancer Agency
- Population and demographic data
 - Consolidation file (MSP Registration and Premium Billing)
 - Vital Statistics Births
 - Vital Statistics Stillbirths
 - Vital Statistics Marriages
 - Vital Statistics Deaths
- Occupational data
 - WorkSafeBC Claims and Firm Level Res.
- Early childhood data
 - Early Development Instrument data
 - Middle Years Development Instrument data
- Spatial data
 - Integrated Cadastrial Information (ICIS) data

External data available

- Health care and health services data
 - Canadian Community Health Survey (CCHS) - access to this data through MoHS is held on until further notice - please contact Researcher Liaison for further details.
 - PharmaNet
 - Perinatal data
- Spatial data

Data are received and incorporated into the data holdings throughout the year. Population Data BC generally receives data between four to ten months after the end of the calendar or fiscal year. It can then take Population Data BC up to six months to validate, link and document the data before they are ready for research use. For information about the availability of a specific data file, check the full listing of data.

The health care services data held at Population Data BC were formerly available through the British Columbia Linked Health Database (BCLHD). Data access requests already submitted to the Ministry of Health Services for BCLHD data will be processed by Population Data BC. Projects with existing access to data will also be supported by Population Data BC. These changes will not require any modifications to existing research agreements, and will not affect timing of receipt of data or ongoing access to data.

HEALTH CARE AND HEALTH SERVICES DATA

Data Set: Medical Services Plan (MSP) Payment Information File

Description: Data on medically necessary services provided by fee-for-service practitioners to individuals covered by the Medical Services Plan (MSP), BC's universal insurance program. Practitioners are separated into: physicians, supplementary benefit practitioners (physiotherapists, massage practitioners, naturopathic physicians, etc.), and out-of-province practitioners.

Date Range: April 1, 1985 onwards

Data Set: PharmaCare

Description: PharmaCare is BC's public drug insurance program that assists BC residents in paying for eligible prescription drugs and designated medical supplies.

Date Range: January 1, 1985 onwards

Data Set: Discharge Abstract Database (Hospital Separations)

Description: Data on discharges, transfers and deaths of in-patients and day surgery patients from acute care hospitals in BC.

Date Range: April 1, 1985 onwards

Data Set: Home & Community Care (Continuing Care)

Description: Information on transactions for individuals receiving services paid by the Continuing Care Division, BC Ministry of Health Services. Transactions relate to clients who are publicly-funded residents of long-term care facilities, assisted living facilities, family care homes and group homes, clients in adult daycare programs, and clients receiving home care and home support services.

Date Range: January 1, 1990 onwards

Data Set: Mental Health

Description: The Mental Health data set contains administrative data in several files that were created using tables in the Mental Health Data Warehouse (MHDW). The mental health data we have are the Minimum Reporting Requirement (MRR) tables from the MHDW at the Ministry of Health Services. The MRR is now the requirement for all HAs in reporting on all patient/clients receiving mental health services in the community. The mental health data are a snapshot from a continuously updated relational database system with files such as client, care episodes, and service events.

Date Range: April 1, 1986 onwards

Data Set: BC Cancer Agency Registry Data

Description: Information on all cancers (of BC residents at diagnosis) reported to the BCCA.

Date Range: January 1, 1985 onwards

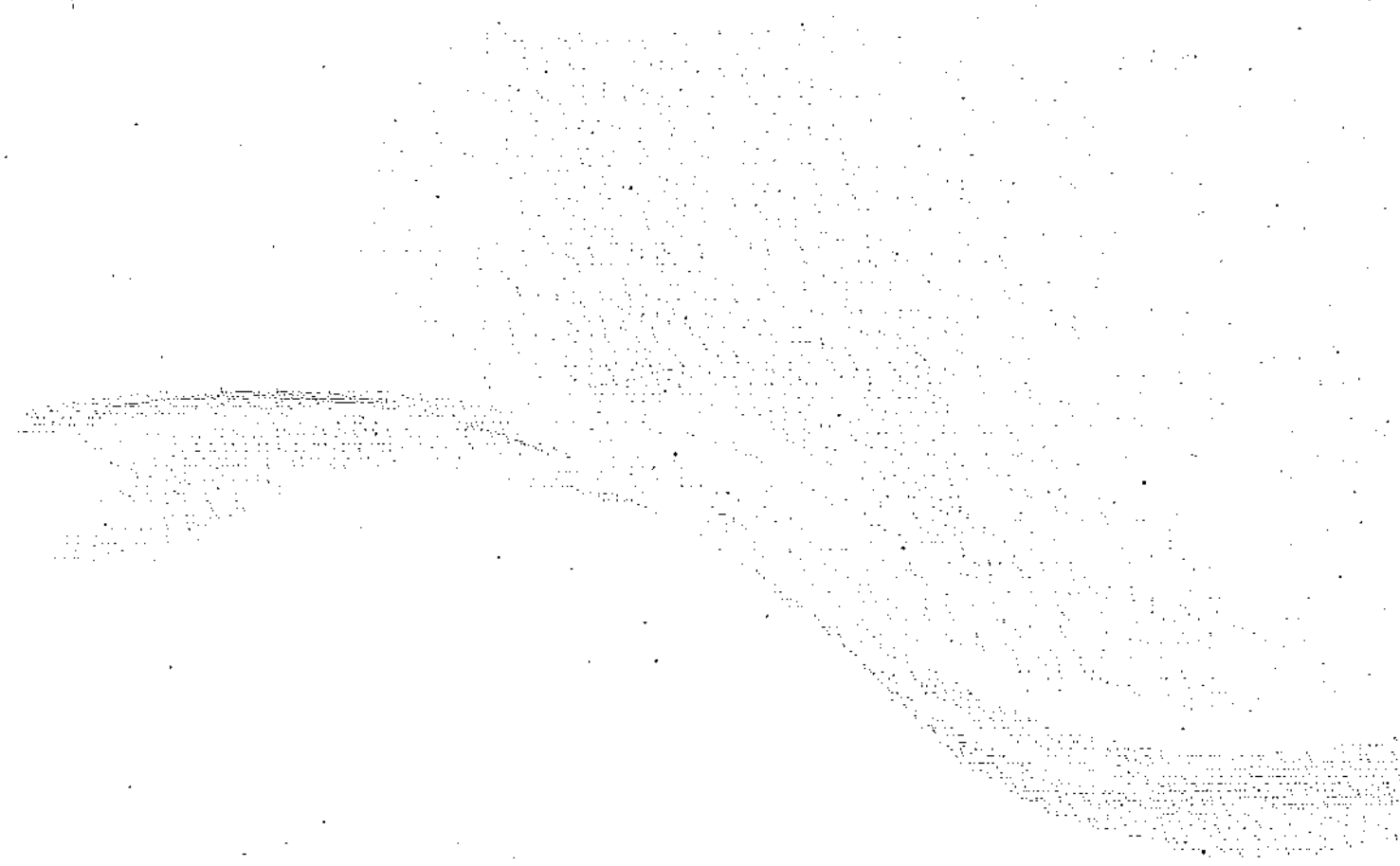
Appendix C: Ministry of Health Data Selection Criteria for Open Data

The criteria the ministry is using for which data could be released as Open Data are set out in its Open Data Implementation Plan, page 2; they are:

1. The ministry owns and/or controls the data (this includes data originally created by health authorities but now held and controlled by the ministry);
2. The release of the data creates no unreasonable risk to personal privacy. This generally means that no primary, person-based data sets will be released (i.e., no data that identifies an individual or would allow an individual to be identified);
3. There are no other substantive legal or policy prohibitions against releasing the data (e.g., legislative protections, policy or contractual requirements or other grounds as set out in the BC Open Information and Open Data Policy);
4. Easily understood descriptive information (metadata) for the data exists or can be developed; and,
5. The data is in a common machine readable format or can be produced in such format.

Pages 483 through 484 redacted for the following reasons:

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Ministry of Health Open Data Implementation Plan

October 2011



Ministry of
Health

Ministry of Health Open Data Implementation Plan

1. Purpose

This document sets out an overall plan for the public release of Ministry of Health data in accordance with the Government of British Columbia's Open Information and Open Data Policy.¹

2. Overall Objectives and Guiding Principles

In July, 2011, Government signalled its clear intent to make government-held data available to the public for their use, adaptation, and distribution, whenever possible, by issuing the Open Information and Open Data Policy. According to this Policy, the overall objectives of the initiative are to increase the transparency and accountability of Government and to encourage citizen participation and engagement with Government.

The Ministry of Health is responsible for the overall direction and funding of the province's health services which comprise the largest and most costly social program funded by Government. In the course of exercising its responsibilities, the ministry creates and collects a vast amount of related data, so the ministry is in good position to make a significant contribution to the Open Data initiative. Much of the ministry's data is originally created at the point where health services are delivered to individual citizens. These services include those that are funded directly by the ministry (e.g., most physician services, pharmaceutical billing and use), as well as those that are delivered by the health authorities (e.g., acute care, home and community care, mental health and substance use services, and public health).

There are some specific criteria and requirements identified in the Open Information and Open Data Policy governing what kinds of data should be released through Data BC. In keeping with the spirit of the Policy, the guiding principle in this plan is that much of the data held by the ministry should be considered suitable for public release provided that it is in a form that complies with the ministry's data stewardship responsibilities, including the protection of citizens' personal health information. Personally identifiable data will not be released as open data, nor will confidential or incomplete data (e.g., draft or interim data).

Given the volume and complexity of the ministry's data holdings, there will inevitably be a need to release data in a series of phases. However, the ministry can begin to make substantial and useful contributions to the Government's open data holdings in the relatively near term. Over time, the amount and types of data released should grow to the point that it presents a comprehensive picture of the province's health services. As the overall Open Data Initiative proceeds, options will also be explored with Data BC to organize the released data in a manner that makes it easier for users to choose, locate, and compile data of interest.

¹ Open Information and Open Data Policy, link: http://www.cio.gov.bc.ca/local/cio/kis/pdfs/open_data.pdf

3. Selection and Preparation of Open Data

To meet the goals and principles of the Open Data policy, the ministry is establishing and implementing internal processes to ensure a consistent and efficient approach to the selection, preparation, approval and release of open data.

3.1 Selection Criteria

The main criteria used to determine what data should be released are as follows:

1. The ministry owns and/or controls the data (this includes data originally created by Health Authorities but now held and controlled by the ministry);
2. The release of the data creates no unreasonable risk to personal privacy. This generally means that no primary, person-based data sets will be released (i.e., no data that identifies an individual or would allow an individual to be identified);
3. There are no other substantive legal or policy prohibitions against releasing the data (e.g., legislative protections, policy or contractual requirements or other grounds as set out in the Open Data Policy);
4. Easily understood descriptive information (metadata) for the data exists or can be developed; and,
5. The data is in a common machine readable format or can be produced in such format.

3.2 Timeframe and Prioritization

The ministry is committed to being a key contributor to the Open Data BC Catalogue and will approach this work in two phases:

- Phase 1 will involve the early identification of data files that can be immediately added to the Data BC Catalogue and the activities of this phase will run until March 31, 2012.
- Phase 2 will focus on the implementation of a planned approach toward broad disclosure of ministry data with regular and on-going updates.

Given the size and number of the ministry's data holdings, senior staff in each major program area will use their knowledge and understanding of their data holdings to determine the order in which data files from their area should be brought forward for approval in Phases 1 and 2. This assessment will be supported by the ministry's Planning and Innovation Division and Health Sector Information Management and Information Technology (HSIMT) Division. This analysis will generally involve a number of considerations but will include balancing which data would be of most interest/relevance to an understanding of the program area/services in question with what data are, practically, most easily/quickly prepared for release.

Questions to be considered when prioritizing data that appears to satisfy the selection criteria include:

1. Does the data file contain data that is central to the program area's primary purpose (e.g. data presenting overall utilization of the service in question would be an earlier priority than data on a narrower, more detailed aspect of the program)?
2. Has the data already been publicly published or released (on the ministry's website or elsewhere)?
3. Is the data already available in machine readable format or can it be converted with relative ease?
4. Are resources identified to support scheduled updates to the data?
5. Is there a need to engage in any significant consultation with affected parties prior to the data's release?
6. Does the Ministry control the data and will its release pose any privacy or confidentiality risks?

3.3 Data Presentation

The presentation and structure of the data contributed to the Open Data Catalogue is as, if not more, important than the volume of data provided. Accordingly, whenever possible the ministry will prepare data files for release that group related series of data in a useful way (e.g. a larger data file with successive years of data, or data for different geographic areas, on separate tabs would generally be better than dozens of separate files).

The Data BC website currently provides for searches to be conducted by very broad sectors or subject areas (in the case of health data the sector is "health" and the subject is "health and safety") but the only way to search for particular topics within health is to use a keyword search. This means that it is currently difficult to find, in an organized manner, related data files on specific subjects. As the Open Data Catalogue and usage matures, the ministry will work with Open Data BC to refine the structure and presentation of data to best meet user preferences (within the established criteria for data release). Future considerations could include data applications that would allow users to more easily select particular sets of data of interest to them.

4. Process

With the guidance and support of the Planning and Innovation Division and HSIMT ministry program area staff will select and prepare data to be considered for release through Open Data. In order to ensure a coordinated, consistent process, and to comply with the requirements of the Open Data Policy, the following approval process will be used.

1. Planning and Innovation Division and HSIMT staff will work with program area staff to identify data files to be proposed for release and complete the necessary Open Data Assessment Form and Open Data Assessment Checklist, as required under the Government Open Information and Open Data Policy.

2. The completed form and associated package (related material deemed relevant) for the recommended data releases will be forwarded by the senior program manager to the program ADM for approval.
3. Once approved by the Program Area ADM, the form and package will be forwarded to the Office of the Chief Data Steward for review/approval and return to the program ADM.
4. Data files recommended for release will be reviewed by Health Government Communications and Public Engagement, which will conduct appropriate engagement with the Office of the Minister of Health.
5. Forms and supporting materials will be forwarded to the Deputy Minister for final approval and forwarding to Data BC.
6. The Planning and Innovation Division will maintain an overall record of health data added to the Open Data BC Catalogue.

7. Implementation

As described earlier, the volume and variety of data managed by the ministry means that it will be necessary to approach the overall task of releasing ministry data through Open Data BC incrementally. Program staff will use their knowledge and understanding of their data to identify and sequence the selection and preparation of data for release in accordance with the guidance provided in the Government Open Data Policy and the ministry plan.

It will be necessary to take into consideration the internal resources (staff time, money, frequency of refreshes, etc.) required to undertake the related work, bearing in mind that Open Data is a high government priority and the Ministry of Health is well positioned to be a major contributor.

As previously mentioned, the ministry will approach this work in two phases. Phase 1 will set the ministry in motion with the development of this plan and will provide for the first rounds of Health contributions to the Open Data BC Catalogue. The Phase 1 work plan will include milestones and targets for ministry contributions to Open Data BC during the 2011/12 fiscal year.

Phase 2 will build on the experiences and learning from Phase 1 and develop a plan to set the ministry on an ongoing path to contribute to and support the Open Data BC Catalogue over upcoming years.

8. Conclusion

The Ministry of Health will be a significant contributor to the Open Data BC Catalogue, and has developed this plan to ensure an efficient and consistent approach to contributing data. The ministry's Open Data Implementation Plan recognizes that the early contribution of pertinent data is a high priority and that a logical sequence of activities should be undertaken, probably for at least the next year or two, to gradually build and organize a comprehensive set of open data.

**MINISTRY OF HEALTH
INFORMATION BRIEFING DOCUMENT**

Cliff # 925340

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

TITLE: Medical Office Information System Background for Meeting with Northern Medical Society

PURPOSE: To prepare the Minister for a meeting with Northern Medical Society on Friday, April 13, 2012.

BACKGROUND:

An electronic medical record application is used by a physician to manage their practice and patient charts. Common functions in these applications are: patient registration, scheduling, documenting visits, ordering and reviewing tests, writing and managing prescriptions, referral management and clinical decision support.

The Medical Office Information System (pronounced 'MOIS') is an electronic medical record application developed in the early 1990s by a physician in Prince George named Dr. William Clifford. Physicians users are passionate about the improvements in the quality of care they are delivering since implementing the Medical Office Information System.

In January 2005, Dr. Clifford approached the Ministry of Health (the Ministry) for funding to assist with converting the Medical Office Information System to an open-source application that would be made available to a broader range of physicians through a proposed not-for-profit society. The Ministry did not agree to fund this proposal.

Instead, the Ministry and the British Columbian Medical Association (BCMA) agreed to establish a program to procure and standardize up to six electronic medical record applications for physicians to implement. A Request for Proposals (RFP) was issued in February 2007 to select the vendors for the jointly managed Physician Information Technology Office (pronounced 'PITO') initiative.

Dr. Clifford did not submit a proposal to this procurement process. At the time, he was supporting the Medical Office Information System alone. It is believed he did not have the resource capacity to commit his application to a broader provincial initiative.

Since that time, Dr. Clifford has transferred his ownership of the Medical Office Information System to a not-for-profit group called the Applied Informatics for Health Society. The NHA has declared the Medical Office Information System as the preferred electronic medical record system for physicians in the north.

DISCUSSION:

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2 of 2